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TEEN MOTHERS: THEIR WORLD PORTRAYED

by

KAREN JOANNE MYKIETKA

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Dr. M. Doherty-Poirer

Dr. P. A. Field

Dr. B. Munro

Dr. G. Glassford

Date September 2, 1998

Abstract

Ethnographic methods were used to explore the experiences of 13 adolescent mothers who had dropped out of school, in particular, their concerns, issues, use of and need for services were investigated. Most of the participants tended to have a family background characterized by divorce, single parenthood, family dysfunction, and instability; they were independent at a young age, and many of the girls had experienced abuse. The young women enjoyed motherhood and believed it positively affected their life, although they felt criticized and judged by others. Their foremost needs were money and support, yet they also wanted to do things on their own. The greatest barriers to service use were not knowing about available services and not perceiving a need for them. Relationship, the central theme, was at the core of a number of systems including the individual, family and friends, community, services, and society that had a cumulative influence on participants' experience of motherhood.

Dedication

To all those young mothers who do their best under difficult circumstances. And especially to the women who took the time to speak to me openly and honestly about their experiences.

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Table of Contents

I. INTRODUCTION 1

Purpose of the Study 5

Significance of the Study 6

Thesis Format 6

Reflections: "Gaining Entrance" 7

II. EXPLORING THE LITERATURE 10

Adolescence 11
- Adolescent Sexuality 13
- Adolescence in Canada 20

Adolescent Pregnancy 21
- Antecedents to Adolescent Pregnancy 23
- Consequences of Adolescent Pregnancy 27
  - Health 28
  - Psychological 29
  - Social 29
  - Education 30
  - Economic 32
  - Repeat pregnancy 33
  - Families of adolescent mothers 34

Interventions for Pregnant and Parenting Teens 35

Methodological Limitations of the Existing Research 40

Unresolved Issues 42

Review of Relevant Qualitative Studies 45

Reflections: We Know So Much Yet So Little 50

III. METHODS 52

Rationale for Qualitative Methodology 52

Ethnography: An Overview 53

Reflections: Research Methods 54

Research Design 57
The Participants 58
Data Collection 60
Interviews 60
Observations 63
Focus Group 64
Data Management 65
Data Analysis 65

Research Standards 67
Credibility 68
Applicability 69
Audibility 70
Confirmability 70

Ethical Considerations 70
Ethical Review 70
Informed Consent 71
Confidentiality 72
Anonymity 72
Risks & Benefits 72

Reflections: My Subjectivity 73

IV. CONTEXT 75

Reflections: From Them to Me to You 76

Characteristics of Participants 76
Interview Participants 77
Focus Group Participants 78

Family Background and Past Experience 79

Circumstances Surrounding the Pregnancies 86

School History 93

Complexity and Change 99

V. FINDINGS **103**

Pregnancy 103
Finding Out 103
Sharing the News 105
Options 106
Support 108
Services 110
Prenatal doctor visits 110
Health for two 112
Prenatal classes 113
Labour & delivery 114
Difficulties 117
Enjoyed Pregnancy 118

Parenting 119
Adjusting to Motherhood 119
Support 121
Health nurse 123
Case workers 124
Young mothers support group 125
To Ask or Not to Ask? 126
Managing Financially 127
Student finance 129
Social assistance/child welfare 130
Being a Teen Mother 133
Concerns 135
Needs 136
School 138
Future 143

Themes 145
Perceptions: "I believe..." 146
It's better to parent when young 146
I am a good mother and having a child has positively affected my life 147
I can only relate to people of similar age and circumstance 149
I get criticized, judged, and treated differently ... 151
I Want To Do It By Myself 153
Barriers to Service Use 153
Internal barriers 154
External barriers 155
Importance of Rapport and Relationship 157
Where are the Daddies? 160
Unhealthy Pattern of Relationships 163

Reflections: Style and Unexpected Findings 167

VI. DISCUSSION, CONCLUSIONS, AND IMPLICATIONS 169

The Model 169

The Individual 172
Sexuality, Contraceptive Use, and Pregnancy 172
Motherhood 176
Perceived Needs and Internal Barriers 181

Family & Friends 184
Context 184
Family Support 188
Putative Fathers and Boyfriends 191
Friends 196

Community 199

Services 201

Society 207

A narration of Influences 210

Conclusions 211

Implications 213

Recommendations 217

Suggestions for Further Research 220

Reflections: How does this study relate to health promotion? 221

Strengths and Limitations of the study 223

Summary 225

Reflections: The Research Process 227

REFERENCES 230

Appendices

A: Estimated Adolescent Reproductive Health Status 243

B: Advertisement For Participants 244

C: Sample Interview Guide 245

D: Individual Consent 247

E: Interview Background Data Form 249

F: Additional Questions 251

G: Revised Intervew Guide 252

H: Focus Group Consent 254

I: Focus Group Participant Information 255

J: Focus Group Interview Guide 259

K: Summary Of Participant Characteristics 260

L: Pregnancy Data 261

List of Tables

Table 1 Sex, pregnancy and age 87

Table 2 Contraceptive use 87

Table 3 Pregnancy and school dropout 96

Table 4 Community differences 199

List of Figures

Figure 1 Model of influences on the experience of teenage motherhood..... 170

Chapter I

INTRODUCTION

Teen pregnancy is an increasing social problem despite the fact that the rate of teenage pregnancies—and live births—has declined substantially over the years (Wadhera & Millar, 1997). The public concern is over the fact that the majority of teens who give birth are single and choose to keep their babies rather than place them for adoption. This trend towards single teenage parenthood coupled with research reporting the negative health, social, and economic consequences of early childbearing have alarmed many professionals and the general public.

Wadhera & Millar (1997) report an overall drop in the teenage pregnancy rate (pregnancies per 1,000 females aged 15 to 19) in Canada over the last two decades from 53.7 in 1974 to 48.8 in 1994. The lowest teenage pregnancy rate was 41.1 per 1,000 in 1987 with increases almost every year since then. Only slightly over half of the teen pregnancies in Canada today end in a live birth versus two-thirds in 1974. The shift in outcomes is due to an increasing number of teenagers having abortions, 45% in 1994 compared to 26% in 1974.

Although the increasing number of teenage girls aborting unwanted pregnancies is troubling, the focus of concern appears to be on the large number of teenage women who become pregnant and choose to keep their babies. In the 1960's, the norm was for teenagers to place their babies for adoption with only 10% of girls keeping their babies. Today the situation is reversed. Hechtman (1989) reports that 96% of teenage mothers decide to parent their children. The majority of teenage mothers also tend to be single.

Eighty-one percent of teenagers who had a baby in 1994 were single compared to only 25% in 1974 (Wadhera & Millar, 1997).

Teen pregnancy and parenting is a public concern because it is linked with numerous negative consequences for the mother and child as well as society. Pregnant adolescents are at increased risk of pregnancy complications and poor birth outcomes such as premature delivery, low birth weight babies, and neonatal death (Hofferth & Hayes, 1987). It is believed that poor perinatal outcomes are due more to lack of adequate nutrition and appropriate prenatal care than to maternal age (Hechtman, 1989; Klerman, 1993; Zuckerman et al., 1983). Furthermore, Hechtman (1989) reports long term adverse effects on the children of adolescent mothers including poorer performance in school, more learning disabilities, and excessive aggression and distractibility.

The consequences of early childbearing on the mother are multiple and pervasive; they include negative emotional, health, educational, economic, and social effects. According to Hechtman (1989) becoming a parent during the teenage years adds to the "crisis of adolescence" and complicates the issues of identity, autonomy, and control, which can overwhelm the adolescent. Teenage pregnancy is associated with a higher incidence of life threatening conditions especially for pregnancies in early adolescence (Hechtman, 1989). Women who have children during their teenage years are less likely to finish high school on time (Brooks-Gunn & Chase-Lansdale, 1991) and complete fewer years of education than their peers who delay childbearing (Furstenberg, 1976; Winquist Nord, Moore, Morrison, Brown, & Myers, 1992). Adolescent mothers are also plagued by poverty, unemployment or employment in lower paying and lower status jobs, and higher welfare dependency (MacKay & Austin, 1983; Winquist

Nord et al., 1992). Many of these mothers also experience alienation from their family and isolation from friends. In addition, the majority of teen marriages end in divorce and even subsequent marriages are at risk (Phipp-Yonas, 1980). Despite all the research, the relationship between adolescent pregnancy and the negative consequences that follow is unclear. Negative long-term sequelae of teenage parenthood are partially due to preexisting differences in personality, family background, and environmental conditions (Steven-Simon & Lowy, 1995; Winquist Nord et al., 1992).

There is no single or simple explanation for teen pregnancy. Many complex and interrelated variables (social, economic, educational, cultural, and psychological) interact to form the "antecedents" or determinants of teen pregnancy (Edwards, 1995). Adolescents are reaching sexual maturity earlier and engaging in sexual activity at younger ages. Their ability to think, reason, and make decisions is limited by their cognitive development, and sometimes they lack appropriate knowledge and skills for sexual relationships. A number of social factors (family dysfunction, lack of parental support, poverty, and need for peer acceptance) and psychological factors (poor self-esteem, feelings of hopelessness, and lack of assertiveness) affect adolescents' decisions regarding initiation of sexual activity and use of contraception (Jorgensen, 1993). Moreover, girls may have different reasons for becoming sexually active, choosing to use or not use contraception, and choosing to parent over other options.

The population of pregnant and parenting teenage girls is not one homogenous group but many diverse and distinct groups (Frager, 1991b; Prater, 1995; Roosa, 1986) that vary in family and cultural background,

socioeconomic status, personal attributes, and school history. Diversity can be seen in the geographical distribution of teen births in Canada. Provincial teenage birth rates (live births per 1,000 females aged 15 to 19) vary substantially from 17.4 per 1,000 in Quebec to 104.5 per 1,000 in the Northwest Territories. In Alberta, the 1994 teenage birthrate was 33.0 per 1,000, which is significantly higher than the national average of 24.8 per 1,000 (Wadhera & Millar, 1997). Alberta Municipal Affairs (1995) reported 39 births to girls under 15 years of age and 3046 birth to girls aged 15 to 19 in 1994. As well, there is great variation in teenage birth rates within a city or region with the largest number of births usually occurring in lower class areas. The Capital Health Region,[1] which averages around 675 teen births a year, reported a teenage birth rate of 29.7 per 1,000 for 1993-94; however, the birth rate within the Region ranged from 6.9 to 73.3 per 1,000 with the highest rate being in the inner city (Capital Health, 1996).

Tremendous variation exists in the pregnant and parenting teen population with regards to their support systems, available resources, and ability to cope (Landy, Cleland & Schubert, 1984; Hayes, 1987; Furstenberg, 1991). These differences affect teen mothers' capacity to respond to the challenge of early parenthood. Certain groups of teen mothers such as school dropouts are at highest risk for adverse outcomes (Stevens-Simon & Beach, 1992). However, impoverished young women who are in high need of services are least likely to access them perhaps due to barriers such as transportation and child care or because of the unstable and transient nature of their lives

[1] In 1994, the Capital Health Region (CHR) included the cities of Edmonton and St. Albert. As of April 1st, 1998, the CHR also includes the County of Stratcona and the County of Leduc.

(Roosa, 1986; Stevens-Simon & Beach, 1992; Weatherley, Perlman, Levine, & Klerman, 1986). The needs and issues of specific subgroups of the adolescent parenting population need to be better understood so that appropriate and relevant programs can be developed.

Too often programs are developed from "professional definitions of the problems, professional judgements about solutions to the problems, and professional criteria of the outcomes of solutions" (Perry & Grew, 1993, p.8). Adolescents are not asked to actively participate in the development of programs (Levin, 1989), and researchers have noted that few studies have asked girls about their perceived needs, views of their experiences, or their desires for support (Thompson, Powell, Patterson, Ellerbee, 1995; Biscaro, 1996). Studies that do include interviews with adolescent mothers often do not ask the participants for their perceptions (Theriot, Pecoraro, Ross-Reynolds, 1991). Qualitative descriptive studies are needed to explore the distinctiveness of adolescent mothers, especially pregnant and parenting teens who are school dropouts because they are at high risk for poor life outcomes and are hard to reach (Arenson, 1994; McGee & Archer, 1988, Burt & Sonenstein, 1984; Quint et al., 1994).

Purpose of the Study

The purpose of this study was to understand the experiences of adolescent mothers who had dropped out of school, in particular, their use of and need for services. Ethnographic methods were used to explore the world through the eyes of teen mothers in the context of their daily lives. The goal was not only to describe their experiences, concerns, and issues but also to reflect on their words to gain greater insight into their situations.

The research question that guided this study was "What are the experiences of teenage mothers who have dropped out of school?" There were four sub-questions:

- What are the concerns and issues of adolescent mothers who have dropped out of school?
- What are their perceived strengths?
- What are their perceived needs?
- What type of services or programs would they find useful and accessible?

Significance of the Study

The goal of this study was two-fold. One, to provide a rich description of a sample of teenage mothers so that others would better understand them. Two, to provide information that health, education, and social service practitioners could use to inform their practice and improve service delivery to adolescent mothers. Information gained in this study is valuable in developing programs and services that are relevant and appropriate to this population. If adolescent mothers perceive services as useful and accessible, they will be more likely to use them; and when their needs are met, they will be better able to take care of themselves and their children. Adolescent mothers' early experiences with professionals and their perceptions of services likely affect their use of services in the future, so it is important that these experiences be positive.

Thesis Format

The purpose of the study, research questions, and significance of the study have been presented previously. The next section of this chapter is a

personal account of how I became involved with a group of adolescent mothers and how rapport was established. A review of the literature on adolescent pregnancy and interventions for pregnant and parenting teens is presented in Chapter II. In Chapter III, the methods used in this research study are outlined. The chapter includes the rationale for selecting qualitative methodology, an overview of ethnography, and reflections on my subjectivity. In Chapter IV, the context of the participants' lives is described and in Chapter V the findings of the research are presented. The findings are discussed in Chapter VI along with the implications for practice, recommendations for action, and suggestions for further research. Chapter VI concludes with my reflections on the research process.

Reflections: "Gaining Entrance"

To create context for this study, I will outline my involvement in a young mothers support group, how it came about, and how it evolved. An interdisciplinary practicum was a requirement for my graduate program. I had attended a presentation about a unique interdisciplinary pilot project that provided crisis intervention and prevention programs to families in a high need area of the city. I approached the project coordinator and we discussed possible practicum projects. We decided that I would work on a project idea for an intensive home-visiting program for new mothers. We developed a plan that included doing a literature review, collecting demographic and socioeconomic data for the region, interviewing key stakeholders, and exploring issues with the target population. I conducted a focus group with teen mothers in April of 1997 because the literature identified them as a high-risk group and because there was a young mothers support group that met weekly at the agency. I

found the group informative and the participants intriguing. After the focus group, I asked if I could continue to attend the support group. My motivation was two-fold. One, I found volunteering very rewarding and I enjoyed working with adolescents. Two, throughout the term I had been exploring maternal and child health issues, focusing on teen mothers as a population at risk, and was considering conducting my thesis research in this area.

The support group, facilitated by a pubic health nurse and an outreach worker, was on a drop-in basis and had been running for approximately one year. There was a core group of 5 or 6 girls ranging in age from 16 to 19 years. The public health nurse left on maternity leave when I began attending, and she was not replaced. The group did a variety of activities such as educational sessions, guest speakers, and crafts. Initially, I was just another participant. After about 4 weeks, the outreach worker moved and was replaced by a new worker. The public health nurse still had not been replaced, so I helped the new outreach worker facilitate the group. During July and August, there were often only one or two girls in attendance, so I was able to connect with some of the girls individually. By mid-September the attendance had stabilized, but the composition of the group had changed. Three girls from the previous year returned along with two new attendees and the occasional drop-in mom; the group members related well to each other. However, real bonding began one day when they decided to go out for coffee after the group; I was invited to join them. Coffee and conversation after the group became a weekly ritual.

At this point, I had solidified my thesis research topic. I attended an agency staff meeting to explain my research project and sought their approval to ask attendees in the support group if they were interested in being

interviewed for my research. After obtaining approval, I explained my research project to the group and asked them to let me know if they or any of their friends were interested. Over the next eight months, I interviewed three current members and one past member of the support group. During this period, I also spent time with the young women and their children and became further involved in their lives. I gave them rides, attended their baby showers, and searched for information for them. I talked with them on the phone occasionally and even babysat a girl's baby one evening. One girl asked me about religions and churches, so I brought her some information on various religions. She expressed the desire to go to church, but she did not want to go alone. I told her that she was welcome to come to church with me. She took me up on the offer and has attended church with me on a number of occasions.

In December, a public health nurse joined the group as a facilitator. After discussions about my role in the group and my involvement with the girls outside the group, the facilitators felt that my role was ambiguous and might be confusing to the girls. They felt my involvement with the girls was going beyond my role as a volunteer, and if I was going to continue volunteering with the support group I should not see the girls outside the group. I decided to stop attending the group at the beginning of February, but I continued to meet the girls for coffee once a week for the next three months.

Chapter II

EXPLORING THE LITERATURE

A review of the literature is usually the first step following the selection of a research area. Exploring the literature identifies gaps in knowledge and justifies the need for the selected research question. There are different views, however, on the extent to which the literature should be used to guide qualitative research (Morse & Field, 1995). The viewpoints on this issue vary between two extremes—from no literature review to an exhaustive literature review. The approach used for this study was an initial critical review of relevant literature as recommended by Morse & Field. I summarized relevant literature being critical of any assumptions, biases, or unwarranted conclusions. The literature helped inform the study, but it did not restrict me to a predetermined framework. Additional literature was reviewed following analysis and compared to the findings of the study. This discussion is presented in Chapter VI.

A number of topics were connected with the proposed research questions. The main topic, of course, was adolescent pregnancy, but this topic was very broad and included a vast amount of published research. Therefore, adolescent pregnancy was combined with four other topics to narrow the search for relevant literature—parenting, student dropouts, quality of life, and services/programs. The topics were searched in four databases—MEDLINE, CINAHL, PSYCINFO, and ERIC—for publications between 1985 and 1998. Due to the large amount of literature published on each of these topics the reviews have, by necessity, been limited to only those aspects that relate to the questions under study.

This exploration of the literature begins with a review of adolescence as a period of development with a focus on adolescent sexuality and sexual behavior. Next, the issue of adolescent pregnancy and its associated antecedents and consequences are discussed. Some of the literature on interventions for pregnant and parenting teens is then introduced. The methodological limitations of the published research are presented, as well as some of the recent debates in the field of adolescent pregnancy. Finally, relevant qualitative studies on teenage pregnancy are reviewed.

Adolescence

Adolescence is the transition period between childhood and adulthood commonly viewed as the teenage years (13 to 19), although it is more precisely defined as the time period beginning with puberty (11-12 years old) and ending with the assumption of adult roles (19-20 years old) (Garbarino, 1985). Rapid physical growth as well as demands for social, intellectual, and emotional growth marks this stage of development. This important developmental period can be stressful and challenging not only for adolescents but also for parents, families, teachers, health care providers, and the community.

The stress and confusion of adolescence may be in part due to its ambiguous nature. Adolescence is ill defined in our society. Teenagers are no longer children, and yet they are not adults; they quickly reach physical maturity, but they are not allowed or capable of functioning in adult social roles. Furthermore, the assumption of adult roles is continually being delayed as social mores change and individuals spend longer periods of time in school.

The adolescent years are divided into three phases—early (11 to 13 years), middle (14 to 17 years) and late (18 to 19 years) adolescence (Sundby,

1995). Puberty and growth spurts begin during early adolescence and growth slows as the teen gets older ending with physical and sexual maturity during late adolescence. Cognitively, early adolescents are usually concrete, present-oriented thinkers unable to consider future consequences of their behavior. As they mature they develop the ability to think abstractly and anticipate long range consequences. Unfortunately, teens do not use this higher ordered cognitive reasoning in all situations (Garbarino, 1985). In their struggle to develop a sense of identity and individuality, adolescents move from dependence on family to dependence on peers. As they mature emotionally, teens are also able to form more intimate relationships.

The limited cognitive and emotional abilities of early and middle adolescents gives rise to egocentrism characterized by concern for one's own activities and needs. This self-centeredness leads to three related notions (Lefrançois, 1989). Imaginary audience is one notion described as the adolescent believing that others are concerned about and judging him/her, which makes the adolescent very self-conscious. The second notion is personal fable, the adolescent believes he/she is special, unique, invulnerable, and protected from consequences. The third notion is hypocrisy that is described as behavior contradicting expressed beliefs.

Adolescence is full of diversity with not all teens developing at the same rate. There are male/female differences with girls maturing on average two years ahead of boys. Although there are differences in development during adolescence, mastery of certain tasks is paramount to a successful transition into adulthood. Adolescents must develop self-identity, autonomy, meaningful relationships, and a personal value system (Sundby, 1995; Swindlehurst, 1986).

The importance of these tasks to the teens themselves is illustrated in data collected by Bibby & Posterski (1992) in their large-scale national survey of 4000 Canadian high school students. They found that the three most important things to teenagers are freedom, friendship, and being loved. "What young people value more than anything else are relationships. They want interpersonal ties and they want to be loved" (p. 9). Part of the task of developing meaningful relationships for adolescents is coming to understand and be comfortable with their sexuality.

Adolescent Sexuality

The onset of puberty brings a rapid increase in height and weight and the development of secondary sex characteristics, which eventually leads to reproductive capacity. Girls usually reach reproductive capacity one year to 18 months after menarche (which occurs around 12 years of age). Increasing levels of pubertal hormones bring on sexual maturation. Both biological processes and social processes influence adolescent sexual behavior (Millar, Christopherson, & King, 1993). Research findings suggest that androgens affect sexual interest, arousal, and motivation. Social norms, on the other hand, facilitate or inhibit sexual involvement and influence forms of sexual expression.

Societal attitudes in North America towards sexuality and sexual behavior have changed dramatically over the past two to three decades. For example, 60% of adults in 1985 approved of premarital sex versus 24% in 1969 (Neilson, 1991). TIME magazine recently reported that two-thirds of adults believe that teen sex is okay (Stodghill, 1998). Attitudes are even more permissive among young people. In the Canada Youth and AIDS study, a

national survey of 38,000 young people from Grades 7, 9, 11, and first year post-secondary, almost 80% reported that they thought it was okay to have sex before marriage if you are in love (King et al., 1988). Stodghill (1998) reports that teens today are very open and almost nonchalant about sex. Sex is no longer taboo to talk about, but rather it is a normal and frequent topic of conversation—no matter where teens happen to be school, home, or the mall.

The media play a major role in shaping attitudes and behaviors regarding sex. Adolescents (and younger children) are bombarded with messages about sex everywhere they turn—in music, movies, television, magazines, advertisements, commercials, even cartoons and comics. Sex is portrayed as a simple physical act with no consequences (physical or emotional). Children and teenagers are saying that they learn about sex from television (Stodghill, 1998), and what they see does not promote healthy sexuality or responsible sexual behavior such as using condoms. This shift to more permissive attitudes has translated into more permissive behavior.

More people are having sex, initiating it at younger ages, and experiencing more sexual partners in less committed relationships (Bibby & Posterski, 1992; Fillion, 1996; Millar et al., 1993). Bibby & Posterski (1992) found 55% of 15 to 19 year olds to be sexually active, which is similar to findings of other Canadian (Fehlauer, 1992; Langille, Beazley, Shoveller, & Johnson, 1994) and American researchers (Millar et al., 1993). Millar and his associates state that age accounts for the majority of variance in sexual activity—as age increases so does the rate of sexual activity. The percentage of youth who reported having had sexual intercourse in the Canada Youth and AIDS study was 25% of Grade 9, 47% of Grade 11 and 75% of first year post-

secondary students (King et al., 1988). Two small studies in different provinces had similar findings (Langille et al., 1994; Schnirer, 1996).

Sexual activity is being initiated at younger ages. Both American and Canadian researchers have found that around three-quarters of males and females had intercourse by the age of 20 (Hofferth & Hayes, 1987; King et al., 1988). This is a three or four fold increase in sexual activity among teenage females since the 1940's and although relatively little change among teenage males (Kinsey, Pomeroy & Martin cited in Neilson, 1991). In 1989, Hechtman reported the average age at first intercourse for girls to be 16. A few years later, results from two Alberta studies found the average age at first intercourse to be 14.92 in a suburban community (Fehlauer, 1992) and 14.45 in a rural community (Schnirer, 1996).

There is a corresponding relationship between age at first intercourse and number of sexual partners (Millar et al., 1993). American statistics from the National Health and Social Life Survey (NHSLS) published in 1994 bear this out. In the cohort of women born between the years 1963 and 1974, 25% had had 2 to 4 partners and 10% had 5 or more partners by the age of 18. This cohort was twice as likely to have had multiple partners by age 18 then women born 10 years earlier (Fillion, 1996). Forty-four percent of sexually active high school students in a North Central Alberta municipality already report having had three or more partners (Varnhagen, Svenson, Godin, Johnson, & Salmon, 1991). A sixteen-year-old girl in Edwards' (1995) study of adolescent sexual behavior in the Edmonton area had already had eight sexual partners.

Millar et al. (1993) state that adolescent relationships and sexual involvement develop along a continuum, and sexual intercourse is more likely

in committed relationships. Discoveries by other researchers lead one to question these conclusions. Although sexual involvement does likely follow a sequence, many adolescents move very quickly from kissing to intercourse (Edwards, 1995; Smith & Udry, 1985; Stodghill, 1998). For example, some teens in Schnirer's (1996) study said they needed to be in a relationship anywhere from one week to a couple years before having sex. Other respondents described sexual involvement in emotional terms such as "when you meet the right person" or "when you both feel comfortable".

Twelve percent of teens in Bibby & Posterski's (1992) survey responded that sex on the first date was okay; this proportion increased to 56% after a few dates. There were large male/female differences with 75% of males approving of sex after a few dates compared to only 40% of females. However, there is not always a consistency between beliefs and behaviors. For example, Lotte's study with female undergraduates revealed that although 92% declared that emotional involvement is necessary for sex "most of the time or always", 42% of the women had had casual sex (Fillion, 1996). Briefly stated, "young people today give every indication of engaging in sex on a level probably never before matched in Canadian history" (Bibby & Posterski, 1992, p. 38).

Not all teens are equally likely to become sexually active. It was previously mentioned that sexual activity increases with age, but there are a number of other variables linked with sexual activity. The following factors increase the likelihood of sexual activity (Hofferth & Hayes, 1987; Jorgensen, 1993; Langille et al., 1994; Schnirer, 1996):

- Coming from a non-intact family,
- Having less educated parents,
- Having sexually active older siblings,
- Parents who initiated sexual intercourse themselves at a young age,

- Having been sexually abused,
- Doing less well in school,
- Having lower educational and occupational aspirations, and
- Presence of other risky behaviors such as smoking, drinking alcohol, and doing drugs.

Many of these conditions correlate with poverty, so in general children from poor families become sexually active younger than children from affluent homes (Jorgensen, 1993).

Why do teens from lower socioeconomic homes tend to become sexuality active at earlier ages than other teens? A number of factors may be related. For example, community norms and/or parental values may be different (Millar et al., 1993; Jorgensen, 1993). There is likely less parental supervision in poor, single-parent homes, so teens have more autonomy and more opportunities for sexual initiation and activity (Stodghill, 1998; Voydanoff & Donnelly, 1990). There is likely a higher incidence of premarital sex and permissive sexual behavior modeled in these families (Edwards, 1995; Schnirer, 1996). Adolescent girls may be seeking the love, affection, and intimacy they lacked at home (Edwards, 1995; Mitchell, 1996); they may be unconsciously looking for the father figure they never had (Klein, 1996). On the other hand, boys more likely see sexual activity as a sign of maturity and social status (Neilson, 1991).

Increasing numbers of young people are choosing to have sex, yet many of them are not protecting themselves from the possible consequences—sexually transmitted diseases (STD's) and pregnancy. Despite an increase in sexuality education and availability of contraceptives, around a quarter to a third of sexually active Canadian teens did not use contraception at first intercourse (Schnirer, 1996; Wadhera & Millar, 1997). American statistics are a

little higher with approximately 40% of teens using no method or an ineffective method of contraception at first intercourse—21% also reported not using any effective method of contraception during their last intercourse (Jorgensen, 1993).

Findings from some American studies show that a large number of adolescents wait a year or longer after initiating sexually activity before seeking contraception (Koenig & Zelnik, 1982; Mosher & Horn, 1988). However, teen clients surveyed at a clinic in an Alberta city only reported an average delay of three months (Bonham et al., 1987). American investigators found that the most common reason given for the delay in seeking contraceptives was "I just didn't get around to it". Other reasons centered on fear (of side effects, of parental discovery, or the physical exam) and unwillingness to make a conscious decision about sexual activity ("I wasn't planning to have sex") (Stevens-Simon & McAnarney, 1996). Attitudinal and perceptual barriers appeared to be a greater problem in contraceptive use than lack of knowledge or lack of access.

Students surveyed by Varnhagen and her associates (1991) expressed responsible attitudes towards buying and using condoms. Obviously, knowledge and attitudes are not always translating into behavior—only three quarters of the youth even claimed to use contraception. Bibby & Posterski (1992) found that 85% of teens have taken sex education courses and 9 out of 10 claimed they were fairly knowledgeable about contraceptives. Knowledge, however, is not enough. Jorgensen (1993) states that contraception use requires knowledge, information, motivation, personal and inter-personal skills, and a positive self-concept.

Data from an Alberta study (Archibald, Schnirer, & Hess, 1998) quantify some differences in contraception use. The following is the percentage of teens who used contraception at first intercourse in relation to a number of variables.

- Age: 58% of those 14 or younger versus 75% of those 15 or older.
- Prior discussion of contraception with partner: 35% of those who did not discuss versus 83% of those who did discuss.
- Coercion: 51% of those felt coerced versus 72% of those who did not.
- School grades: 66% of those whose GPA was less than 80% versus 92% of those whose GPA was 80% or higher.
- Student employment: 48% of those with no job versus 83% of those with a job.

The obvious consequences of unprotected sexual activity, STD's and pregnancy, are the usual focus of public attention; however, the emotional impact of early sexual activity can also be damaging, and it is often ignored. Physiological changes, psychological needs, and social pressures are pushing adolescents into sexual relationships for which they are not ready. Physical intimacy should be an extension of emotional intimacy in a committed loving relationship, and a sense of identity is a prerequisite for developing intimacy (Erikson cited in Edwards, 1995). Becoming sexually involved before developing a strong sense of identity may negatively impact identity development and lead to sexual problems (Shen, 1982). Adolescents, especially those in early or mid stages, are not emotionally mature enough to deal with the impact of sexual activity.

Although half of the students in the Canada Youth and AIDS study reported that sex without love is not satisfying (King et al., 1988), once teens have first intercourse they tend to have more sexually permissive attitudes and behaviors (Millar et al., 1993). Some teens have a period of prolonged abstinence after their first sexual experience, but many others start a pattern of serial monogamy—a series of short although exclusive sexual relationships. This pattern of sexual behavior established during the teen years often continues into adulthood. "Unless we help adolescents become aware of these needs [love and affection] and how they influence sexual behaviors, they will develop immature, ineffective, unsatisfying relationships and sexual habits that will carry into adulthood" (Hajcak & Garwood quoted in Edwards, 1995, p. 25).

Adolescence in Canada

As noted above, the experience of adolescence and adolescent sexuality is greatly affected by context; thus, a brief discussion on the Canadian context is warranted. All information and statistics are from Steinhauer (1997) unless otherwise indicated.

There are 8 million people under 20 years of age in Canada—over 2 million are between 15 and 19 years old. One in four teens say their natural parents are divorced or separated (Bibby & Posterski, 1992). Twenty percent of children and youth are growing up in poverty. Research has shown that poor children have twice as many health, emotional, and academic problems, and they have three and a half times more conduct disorders, which suggests they are on a path to delinquency. Despite the fact that virtually all students say they intend to finish high school and the majority aspire to go on to post-secondary (Bibby & Posterski, 1992), the average school drop out rate is 18-

21%. Forty percent of those who drop out do so before completing Grade 10. The drop out rate is at least double for children growing up in poor families, in single-parent families, in violent and abusive families, or on Indian reserves. Youth also have difficulty finding work; their unemployment rate is usually double the national adult unemployment rate.

Approximately one in five children and youth meet the criteria for at least one psychiatric disorder (two-thirds of these meet the criteria for two or more disorders). A large number of teens are involved in risky behaviors. Results from an Alberta study indicate: 1 in 4 smoke, 1 in 5 have either seriously thought about or attempted suicide, half have experienced violence, and 60% say they drink alcohol (Armstrong, 1998). "The good news is that 75% of our children and youth are doing just fine. But the bad news is that one in four of our children enters adult life with significant emotional and/or behavioral and/or academic and/or social problems" (p.1). Furthermore, two-thirds of the children have more than one of these problems—pregnant and parenting teens are one population that often suffer from many problems.

Adolescent Pregnancy

Births to females age 15 to19 comprise only about 6% of all Canadian births (Wadhera & Millar, 1997). Despite the fact that only a small proportion of total births are to teens, there are a number of trends relating to adolescent pregnancy that are cause for concern. The pregnancy rate for 15-19 year olds increased by 20% between 1987 and 1994. One in twenty females age 15 to 19 in Canada becomes pregnant every year—that is approximately 47,000 teen pregnancies annually. The pregnancy rate is more than double for 18-19 year olds compared to 15-17 year olds—76.2 per 1,000 as compared to 30.2 per

1,000—which is not surprising considering more older teens are sexually active.

More teens are also choosing to resolve their pregnancy by abortion: 50% of all pregnancies to 15-17 year olds and 42% of those among 18-19 year olds end in abortion (Wadhera & Millar, 1997). Teens account for 20% of all abortions performed in Canada; some teens are even having repeat abortions. Of those teens who carry the pregnancy to term very few choose to place the child for adoption. It was estimated that 80-90% of Canadian teenage women who carried their pregnancy to term in the early 1980's chose to keep their baby (Macdonnell, 1981; MacKay & Austin, 1983; Schlesinger, 1985). It is likely that even fewer girls surrender their baby today. A hospital social worker in the Capital Health Region stated that it is becoming very rare for teen mothers to place their baby for adoption (L. Butler, personal communication, June 23, 1998). The majority of teenage girls who chose to keep their baby are becoming single parents—nationally Wadhera & Millar (1997) report 81% of teen mothers are single, in Alberta 94% are single (Alberta Family & Social Services, 1995). Another alarming fact is that a significant proportion of births to teens are not first births. Nine percent of births to 15-17 years olds and 20% of those to 18-19 year olds in 1994 were second or higher order births.

As reported earlier, anywhere from 25-35% of teens are having unprotected sex, but non-use of contraceptives does not mean that pregnancy is wanted as many factors affect contraceptive use. It is difficult to determine exactly how many of these pregnancies are unplanned, but estimates run from 70-95% (ACPH, 1996; Furstenberg, 1991; Yoos, 1987). Approximately one-half of teen pregnancies occur within six months of first intercourse (Lefrançois,

1989; Sells & Blum, 1996). The risk of pregnancy is a function of sexual activity (age at first sex, frequency of sex, and number of partners) and contraceptive behavior (decision at first intercourse, frequency of contraceptive use, and effectiveness of method). Only 11% of females who use contraception consistently get pregnant within two years of first intercourse versus 66% of those who do not use contraception consistently (Jorgensen, 1993).

Antecedents to Adolescent Pregnancy

Teen pregnancy occurs among all social, economic, religious, and ethnic groups, but pregnancy and birth rates can vary substantially among groups. Researchers have and continue to look for factors that distinguish between teens who get pregnant and those who do not. The only universal antecedent to pregnancy is intercourse. Of those teens who are sexually active the most likely teens to get pregnant are obviously those who do not consistently use effective contraception; although, it is possible that some teens get pregnant even though they consistently use "effective" contraception. Phipps-Yonas' (1980) claims that "there is no unique psychological profile common to most, much less all, pregnant adolescents" (p.407), yet investigators continue to search for variables that correlate with teen pregnancy; and not surprisingly, many of them are the same factors that influence initiation of sexual activity and contraception use.

So many complex and inter-related variables interact together to form the "antecedents" to teen pregnancy that it is virtually impossible to untangle their individual effects and prove causality. Data on antecedents are only correlational. Nevertheless, there are a variety of developmental, social, and psychological factors that may influence teen pregnancy. Early physical

maturation is correlated with early sexual activity and the earlier the age at first intercourse the higher the pregnancy risk. Girls under 15 years old are more than twice as likely to become pregnant within six months of first intercourse than 18-19 years olds (Kryzanowski, 1988). This is primarily due to their level of cognitive functioning. Early and even mid adolescents are plagued by magical thinking such as the belief that "It won't happen to me", and they have not developed sophisticated reasoning ability and effective decision making skills. Of course, ignorance or misunderstanding regarding sexuality, reproduction, and contraception also increases adolescents' pregnancy risk.

Social factors within the family and society at large appear to have the greatest impact on teenage pregnancy. A great deal of the American research focuses on ethnic and cultural differences because the pregnancy and birth rates for non-whites (especially blacks) are very high, often double those of whites. A significant portion of the difference in pregnancy rates is eliminated in studies which control family incomes and parental education, but there still seems to be a cultural effect (Jorgensen, 1993). It is believed that blacks have more positive attitudes towards early childbearing (it is part of their cultural script) and see children as a personal and social asset (Swindlehurst, 1986). However, poverty and the variables associated with it account for much of the variability in teen pregnancy (Furstenberg, 1991; Hayes, 1987; Voydanoff & Donnelly, 1990). Teens of lower socioeconomic status have lower educational and vocational aspirations and may perceive their life options as limited; therefore, they may see little reason in postponing childbearing (Jorgensen, 1993; Stevens-Simon & McAnarney, 1996). They also grow up in a very different context than higher status teens—they come more likely from single-parent

homes that model more permissive sexual attitudes and have less parental supervision.

In Canada, Oz & Fine (1988) conducted a study in a predominantly white, Anglo-Saxon community in southwestern Ontario. They used snowball sampling to recruit 39 teen mothers (TMs) and 35 of their friends who were not mothers (NMs) so that all subjects came from similar sociodemographic backgrounds. Both of the groups became sexually active at an average age of 15; however, they differed significantly in three areas: home stability, sibling deviance, and ambitions. There was little difference in the marital status of the TMs' and NMs' parents; however, the TMs only had a stable home environment until age 14 as compared to 17 for the NMs. This is further supported by the fact that 44% of the TMs spent time in foster care versus only 6% of NMs. The higher incidence of deviant behaviors among the TMs' siblings also supports the notion of increased family dysfunction. Another factor of dysfunction was sexual abuse. Almost two and half times the number of TMs (33%) as NMs (14%) were sexually abused. Moreover, the TMs usually suffered from repeated abuse by several family members while the sexual abuse in NMs was more likely a one-time rape by a stranger.

Furthermore, education and boyfriend characteristics, which the authors call "ambitions", were most highly correlated with teen mother status. For example, sixty-two percent of the TMs dropped out of school prior to becoming pregnant and 15% dropped out after they became pregnant. They also reported spending much of their time in pool halls and bars, and their boyfriends were more likely to be violent, substance abusers, school dropouts, and have a history of incarceration. It seems as though their lack of

educational ambitions led them to spend time with boys who also lacked ambition. So, in general, TMs grew up in an unstable environment with multiple elements of dysfunction.

In addition to environmental factors previously outlined, teen mothers may also be affected by a number of psychological or emotional variables such as poor self-esteem, lack of assertiveness, feelings of hopelessness, a fatalistic attitude, and the need for self-worth, love, and purpose (Black & DeBlassie, 1985; Furstenberg, 1991; Patterson, 1990). Ambivalence towards postponing childbearing is a major problem cited in the literature. For example, Rainey and colleagues surveyed 200 never-pregnant teens accessing routine health care in Colorado (cited in Stevens-Simon & McAnarney, 1996). They found that forty percent of the teens said they "wouldn't mind getting pregnant" while 10% admitted they wanted to get pregnant. Teens who consciously or unconsciously desire to become parents for whatever reason—to escape intolerable home life, to have someone to love, to solidify a relationship with a partner, concern about their fertility—are less likely to take measures to prevent pregnancy.

Parenting is an end point in a sequence of events, and the teenage girls who end up becoming parents are likely very different from the girls who did not go down that path (see estimated adolescent reproductive health status Appendix A). It appears that at each level (sexually active/not active; contraceptive use/no use; pregnant/not pregnant; abortion/continue pregnancy; adopt/parent) it is the teens from more disadvantaged backgrounds that are on the road to premature parenthood. When faced with an unplanned pregnancy, girls from higher socioeconomic intact families who do well in

school are more likely to choose abortion (if they have a favorable attitude towards this option) or adoption (if they are opposed to abortion) (Jorgensen, 1993). The girls who are from lower socioeconomic homes (usually single parent families), who have dropped out of or are performing poorly in school are more likely to become parents. Therefore, teen pregnancy often adds to the impoverishment of existing socially disadvantaged groups (Stevens-Simon & McAnarney, 1996).

Consequences of Adolescent Pregnancy

Pregnancy and the transition to parenthood can be a wonderful yet stressful experience for adult women. Trying to integrate the new role of parent into their life as wife and career woman can be very challenging. Plus, parenthood affects the dynamics of the romantic relationship and influences career and employment choices. When pregnancy and adolescence occur simultaneously there is a double crisis. Pregnant and parenting teenage girls need to continue with the developmental tasks of adolescence while at the same time assuming adult and mother roles. Not only is the number of demands overwhelming, but they can also be in direct conflict (Adams & Kocik, 1997). Pregnancy disrupts the process of emancipation and independence as it forces the teenage girl to be dependent on others. It also limits the girl's opportunity to explore various roles and develop a sense of self (Sundby, 1995). In addition, early parenthood disrupts the family of origin and may create conflict.

There are many long lasting effects of early childbearing and childrearing on the teenage girl, the child, and society as a whole. Adolescent mothers' life outcomes are thought to be adversely affected in a number of

areas: health, psychological, social, educational, and economic (Hayes, 1987; Horowitz, 1995). As well, the children of adolescent mothers tend to be handicapped physically, intellectually, and economically (Neilson, 1991). Both the adolescent mother and her children can become an economic burden to society (Stevens-Simon & McAnarney, 1996).

Research on the consequences of teenage parenthood will be explored; however, there is ongoing debate over the relative impact of preexisting socioeconomic background versus adolescent pregnancy on future outcomes (Furstenberg, 1991). The complexity of the issue and the number of variables involved make it difficult to determine cause and effect. It is likely that the consequences of teenage childbearing are not as severe as originally thought. This debate will be discussed further in the section "Unresolved Issues".

Health

Adolescent pregnancy is associated with increased risk of life threatening conditions such as toxemia, anemia, nutritional deficiencies, urinary tract infections, and prolonged labour (Black & DeBlassie, 1985; Stevens-Simon & White, 1991). Perinatal health risks for the baby include prematurity, low birth weight, and neonatal death. Initially, it was thought that negative perinatal outcomes were due to maternal age; however, investigators now believe that adverse health consequences are due primarily to factors relating to low socioeconomic status such as poor prenatal care, poor education, inadequate nutrition, and stress (Frager, 1991a; Hechtman, 1989; Klerman, 1993; McAnarney, 1985; Stevens-Simon & Beach, 1992).

The effect of socioeconomic status on perinatal outcomes can be seen in the incidence of low birth weight in Canada. The lowest income neighborhoods

have 1.4 times the number of low birth weight babies than the highest income neighborhoods (Ng & Wilkins, 1994). However, poverty does not account for all perinatal risk. Adolescents under 15 years of age are still at greater risk even after controlling for socioeconomic status (Fraser, Brockert, & Ward, 1995; Hayes, 1987; Ostrem, 1995) which is potentially related to their lack of physical maturity. Second or later parity births are also at higher risk especially if pregnancies are less than one-year apart (Lefrançois, 1989; Winquist Nord et al., 1992).

Psychological

Even if physically healthy, pregnant and parenting adolescents may be psychosocially stressed (Stevens-Simon & Beach, 1992). The adolescent may have concerns about health and body image, her new role as a mother, school, and social isolation (Sundby, 1995). Moreover, she may also be facing numerous problems with finances, housing, childcare, her family and her partner (Adams & Kocik, 1997; Bonham et al., 1987). Jorgensen (1993) reports that teen mothers experience more stress, feelings of helplessness, despair, depression, and low self-esteem than older mothers. Other psychological problems may result from an inability to master tasks of adolescence such as identity formation and autonomy (Black & DeBlassie, 1988).

Social

Teen mothers often experience alienation from family members and isolation from friends (Hechtman, 1989; Parks & Arndt, 1990). They are also more likely than their childless peers to marry by age 20, and their marriages are plagued by discord and divorce (Furstenberg, Brooks-Gunn, & Morgan, 1987). One in five teen marriages end within the first year and three in five

within six years (Oz & Fine, 1988). Even subsequent marriages tend to be troubled (Phipps-Yonas, 1980). These factors contribute to teen mothers' social isolation.

Education

Educational attainment is one factor impacted by teenage childbearing that has far reaching consequences. Lack of education begins a downward spiral into low-paying jobs, unemployment, poverty, and welfare. The adolescent mother's level of education both prior to and after her first child is the mediating factor in her success later in life (Adams & Kocik, 1997). For example, Black & DeBlassie (1985) report that adolescent pregnancy is the most common cause of early school leaving in the United States. Although more teen mothers continue their schooling today than in previous years, there remains a gap in educational attainment between teen mothers and their childless peers (Furstenberg et al., 1987; Upchurch & McCarthy, 1989; Klerman, 1993).

In a Canadian study, Macdonnell (1981) compared the educational level of 353 single adolescent mothers and 332 married mothers in Nova Scotia. Only 20% of adolescent mothers compared to 65% of married mothers completed high school. Similarly, a study of single, adolescent mothers in four Ontario cities indicated that 60% of the women had Grade 10 or less and that one-third had no plans of continuing school (MacKay & Austin, 1983). In a five year follow-up of teenage mothers in Baltimore, United States, Furstenberg (1976) found that one-half of the women had completed high school and one-half had not. Of those women who had not completed high school, 45% had never returned to school following childbirth, 40% had returned for some

period of time, and 16% were still in school. In a 17-year follow-up of the same women, Furstenberg et al. (1987) found that 70% of the women had graduated from high school and 30% had some post-secondary education. Although half the teenage mothers had dropped out of school, many returned to school and received their high school diploma later in life.

In another American study, Upchurch and McCarthy (1989) used three American national surveys to compare the graduation rates of cohorts of adolescent mothers from three different time periods: (1) 1940's and 1950's, (2) 1960's and 1970's, and (3) late 1970's and early 1980's. The proportion of teenage mothers who completed high school by the time they were 21-29 years old increased from 19% in 1958 to 29% in 1975 to 56% in 1986. However, teen mothers were still much less likely to graduate than women who delayed childbearing until after 20 years old (56% versus 91%). The younger the adolescent at first birth, the less likely she was to graduate from high school. The most likely to graduate were women from advantaged backgrounds. Although the proportion of adolescent mothers graduating from high school is higher today than in previous decades, their relative educational disadvantage persists because their peers who delayed childbearing also increased their years of education.

There is debate about the cause-effect relationship between childbearing and educational attainment. It is difficult to determine the relative impact of childbearing versus preexisting differences on school drop out. For example, Upchurch and McCarthy (1990) examined the temporal sequence of pregnancy and dropping out; they found that teens who dropped out before becoming pregnancy and those who dropped out after becoming pregnant had similar

rates of graduation. Therefore, it would seem that preexisting differences in personality and family background led to school drop out and teen pregnancy.

Stevens-Simon & Lowy (1995) report that school drop out often precedes pregnancy and that school attendance and achievement prior to conception may be good predictors of school attendance and achievement after delivery. Similarly, Upchurch (cited in Winquist Nord et al., 1992) reports that high school graduation is less likely for adolescent mothers who dropped out of school prior to conception. However, this was not true in an Ontario study. Oz & Fine (1988) reported that 62% of the teen mothers in their sample had dropped out of school prior to becoming pregnant and an additional 15% dropped out after they became pregnant. After the child's birth, 15% of the teen mothers returned to school all of whom had dropped out before their pregnancies. Educational ambition is another index that has been use in predicting educational attainment. Eighty-five percent of the women in Furstenberg's (1976) sample who had high ambition graduated from high school versus 8% who had low ambition. In the end, adolescents who have school problems (dropping out, poor achievement, or behind 1 or more grades) before they become mothers will be less likely to graduate. Those who have high ambitions, remain unmarried, live with their parents, and prevent a repeat pregnancy are more likely to finish high school.

Economic

Poverty is frequently the context within which adolescent pregnancy occurs and is also the context within which 60% of teen mothers live (Phoenix, 1991; Sells & Blum, 1996). Therefore, poverty is both an antecedent and consequence of teenage childbearing. Low levels of education, along with

other barriers such as availability and cost of child care, and flexibility of working conditions, preclude employment for many adolescent mothers and relegate others to low paying/low status jobs (Winquist Nord et al., 1992). Teen mothers have only one-half the income of women who delayed motherhood until their twenties (Black & DeBlassie, 1988). Initially, many teen mothers are forced to rely on welfare. They have little means of supporting themselves and receive little or no financial assistance from the child's father (Neilson, 1991).

One-half of the single adolescent mothers in the Nova Scotia study received welfare at some point during the first 18 months after birth (Macdonnell, 1981). A 17-year follow-up of adolescent mothers in the Baltimore study found that 70% had received welfare at some point, but only 12% were long-term welfare recipients (Furstenberg et al., 1987). Welfare was used as a temporary support after the birth of their child. Over time, more women worked and fewer were on welfare. For example, one-third of the women in the Baltimore study worked in the first year after birth while two-thirds worked the second year. McAnarney (1985) states that adolescent mothers enter the welfare system sooner, but they also leave it earlier than women of similar socioeconomic status who delayed childbearing. The young married mothers faired better than their single counterparts; they were less likely to require welfare and had two times the income of their non-married peers (Furstenberg, 1976).

Repeat pregnancy

Teen mothers have a high rate of rapid repeat pregnancy which affects their ability to complete high school, limits their employability, and increases

their dependence on welfare (Hayes, 1987; Stevens-Simon & White, 1991; Winquist Nord et al., 1992). East & Felice (1996) report that 30% of adolescent mothers have a second child within two years and as time passed it was more likely that the second pregnancy would involve a different partner (71% of second pregnancies occurring 12 to 18 months from the first pregnancy involved a different partner). Gillmore, Lewis, Lohr, Spencer, & White (1997) followed 170 pregnant adolescents from a large city in the Northwest United States. One-half of the sample had a repeat pregnancy by 18 months postpartum; one-third of them chose to have an abortion. Stevens-Simon, Parsons, & Montgomery (1986) state that the majority of repeat pregnancies are unplanned and unwanted; however, ten years later Stevens-Simon, Kelly, & Singer (1996) report that teen mothers seem ambivalent about preventing further pregnancies. Teens who marry, who are younger at first birth, who do not return to school, and who have a history of problem behavior are at higher risk of having a rapid repeat pregnancy (East & Felice, 1996; Gillmore et al., 1997). Adolescent mothers who obtain additional schooling after the first birth and those who have more educated parents are less likely to have a closely spaced second birth (Kalmuss & Namerow, 1994).

Families of adolescent mothers

In addition to the perinatal health consequences discussed above, children of adolescent mothers have a higher incidence of developmental delay, behavior problems, school failure, underemployment/poverty, and unplanned pregnancy (Stevens-Simon & White, 1991). Prematurity and low birth weight contribute to a higher incidence of physical and developmental problems, plus infants are less likely to be immunized or receive regular medical care (Frager,

1991a; Hechtman, 1989). In a 17-year follow-up of black adolescent mothers in Baltimore, it was found that their children were at high risk for school problems (Furstenberg et al., 1987). By age 16, one-half of the children had repeated at least one grade. They also had more misbehavior and initiated sexual activity earlier than children of older mothers. Hechtman (1989) also reports a higher incidence of learning disabilities, excessive aggressiveness, impulsiveness, and distractibility in children of adolescent mothers. A large part of the difference in outcomes can be explained by environment: many of the children born to teenage mothers grow up in disadvantaged neighborhoods, in poverty, and with unstable families (Hayes, 1987). Socioeconomic status does not, however, account for all the differences, maternal age continues to be a risk factor (Klerman, 1993).

Pregnancy and parenting during the teenage years has a large impact on the family of the adolescent. Seventy-five percent of teen mothers live with a parent or relative at least for a short time after the birth of the child (Voydanoff & Donnelly, 1990). Teens are most likely to receive family support if they live with their family and least likely if they live with a partner. The level of support of teen receives depends on the resource availability of her family; support most often comes in the form of financial assistance, childcare, transportation, or emotional support (Jorgensen, 1993). Although intergenerational living arrangements may work well for some, "frequently these complex child care systems are unwieldy, conflict-ridden, and unstable (Furstenberg, 1991, p. 132).

Interventions for Pregnant and Parenting Teens

As the concern over teen pregnancy and its associated negative consequences mounted, programs to prevent teen pregnancy and reduce its

negative effects proliferated. Efforts included primary prevention (prevention of pregnancy), secondary prevention (early diagnosis and appropriate prenatal care), and tertiary prevention (postpartum follow-up to minimize negative outcomes) (Stevens-Simon & McAnarney, 1996). Tertiary prevention programs had a number of different foci including health care services, economic support, child development, and enhancement of life options (Hayes, 1987). However, teen pregnancy and parenting involves such a complex mix of biological, social, emotional, familial, and economic factors and adolescents' biopsychosocial needs are so inter-related that comprehensive programs became the preferred approach.

Comprehensive care programs include prenatal, postpartum, and pediatric health care; educational services; employment training and counselling; family planning services; life planning assistance; life skills training; and parenting education (Hayes, 1987). These multidisciplinary programs can be school or community based, and they offer the services directly or coordinate existing services. "These programs are based on the premise that impoverished adolescent parents require additional encouragement and support to postpone further childbearing and engage in development-promoting activities (Stevens-Simon & McAnarney, 1996, p. 327).

There are mixed reviews on the success or effectiveness of these interventions. Results from three comprehensive programs that operated in the United States between 1980 and 1992 will be reviewed. Following this, programming and evaluation issues will be examined. Finally, an overview of factors and conditions that enhance success will be presented. No Canadian programs are examined because there is limited published literature on

interventions for pregnant and parenting teens in Canada. In an older review, Schlesinger (1986) described four small-scale projects. Two other articles consisted of little more than program descriptions (Holman & Arcus, 1987; Remizoff, 1990).

One of the first programs in the United States was Project Redirection; it was implemented in four cities across the United States in 1980 to improve outcomes for disadvantaged young mothers (Polit, 1989). The programs coordinated a variety of services including counselling, education, employment, parenting, health, and life management. Three strategies were used to increase service use: mentors (community women), individual participant plans, and peer group sessions. After one year the program participants had more favorable outcomes than comparison teens, but after two years the favorable results seemed to have disappeared. Although two subgroups, including school drop outs and welfare recipients, showed significant benefit. At the five year follow-up there was only a modest effect for the sample as a whole. Program and comparison teens were just as likely to have completed basic schooling and both had been pregnant an average of three times. The program had the greatest impact on the most disadvantaged. In the end, however, program participants were no less likely than comparison teens to be living in poverty.

Another comprehensive program (TAPP—TeenAge Pregnant and Parenting Demonstration) ran in three Arizona sites from 1985-1989 (Warrick, Christianson, Walruff, & Cook, 1993). Two school-based intervention models that enrolled participants during pregnancy were compared to three other models. One intervention model was supplemental to a school program while

the other was a stand-alone school program. Both models had five core services: health care, parenting skills curriculum, daycare, counselling, and case management. The supplemental intervention model had the lowest drop out rate (20% as compared to 40-48% for comparison sites at 12 months) and participants enrolled an average of one month earlier. Educational persistence was lower among girls who lived with their boyfriend/husband and those who received public assistance. The strongest predictor of educational persistence was previous school success, but the case management and outreach components of the intervention also resulted in favorable effects on school achievement. The case management component appeared to have the strongest positive effect overall.

More recently, Quint et al. (1994) reported mixed results from the New Chance Demonstration that offered comprehensive education, training, and assistance to highly disadvantaged teenage mothers who had dropped out of school. The demonstration operated in 16 locations in 10 states between 1989-1992. Women were randomly assigned to experimental or control groups. Positive findings were that many participants attained a General Education Development certificate, used better quality childcare, and showed modest improvement in parenting skills. However, they also had high rates of repeat pregnancy, their attendance was sporadic, and more than 80% were still on welfare 18 months after the program. Overall, the experimental group received more of every type of service, but it only did slightly better than the control group: high absenteeism and early termination likely reduced program effects. The authors state that "no program has enabled them [teenage mothers] to escape from poverty to any meaningful existence" (p. XIX).

Many interventions and their evaluations have been criticized for not being scientifically rigorous (Borowski & Macdonald, 1982; Stahler & DuCette, 1991). Some of the positive results may be accounted for by selection bias (Hechtman, 1989; Klerman, 1993). Adolescent mothers who have higher aspirations, increased motivation, effective and meaningful support systems, and attend school are more likely to participate in special programs (Roosa, 1986, Stevens-Simon & Beach, 1992). Moreover, Marsh & Wirick (1991) state that studies lack appropriate comparison or control groups and programs are evaluated as a whole rather than evaluating the effectiveness of separate components. Consequently, to date, the research is inconclusive as to what is causing the positive effects in some interventions.

Interventions may be beneficial, but only a small portion of those in need participate in them (Hayes, 1987; Klerman, 1993; Roosa, 1986). It is estimated that interventions are only serving 20% to 30% of the pregnant and parenting adolescent population (Furstenberg, 1976, Roosa, 1986). Fedak, Peart, & Connolly (1996) report that only 40% of pregnant teens in Brant County, Ontario registered in a teen prenatal program and even fewer attended a majority of the classes. Sporadic attendance in special programs for teens is common according to Quint et al. (1994) and McSparrin (1993). Services are even less likely to reach teens who are not in school (Burt & Sonenstein, 1984; Quint et al., 1994).

Horwitz, Klerman, Kuo, & Jekel (1991) report six features associated with long term success of teenage parents; they define long term success as being employed or supported by a spouse along with a high school education. The features included: (1) having completed more school prior to becoming

pregnant, (2) participating more actively in a program intervention, (3) being in school with no subsequent pregnancy at 24 months postpartum, (4) feeling in control of one's life, (5) little social isolation, and (6) lifetime fertility control (only one or two children after the index child).

Methodological Limitations of the Existing Research

Adolescent pregnancy and parenthood became a social concern in the 1960's and by the 1970's it was characterized as an urgent crisis even an epidemic. This attention fuelled numerous research studies that reported the negative consequences of early parenthood, but many of these studies have methodological flaws which limits their generalizability (Chilman, 1980). Most studies are limited to the first few years after birth so they cannot give an accurate picture of long-term implications of early childbearing. Other researchers have examined the issue retrospectively, often from national survey data, to determine differences between early and later childbearers. These types of studies, however, often do not have data on possible confounding variables and cannot determine the effect of preexisting differences.

Findings from two longitudinal studies (Furstenberg, 1976; Card & Wise, 1978) share a clearer picture of the long term sequelae of teenage childbearing, but we must be cautious in generalizing their findings to today's teenage mothers. Furstenberg's sample was predominantly black women and findings may not be applicable to other ethnic groups, and attrition was a problem in Card & Wise's follow-up of subjects. The major problem is that these studies were conducted with a cohort of teens from the 1960's; the context of teenage parenthood has changed considerably since then (Winquist

Nord et al., 1992). Society was much less tolerant of premarital pregnancy at that time, and access to contraceptives and abortion was more limited.

The fact that more teens today are sexually active means that a broader segment of the teen population may be at risk for pregnancy while at the same time wide availability of contraceptives and abortion may have changed who actually becomes a parent (Winquist et al., 1992). Girls who get pregnant, carry the pregnancy to term, and choose to parent could possibly be different than those who became teen parents in the 1960's and 1970's when abortion was not an available option. The social and economic climate has also changed. There is less social stigma attached to non-marital childbearing and most pregnant teens do not marry the father. There are also fewer jobs for people with limited education, especially jobs that will allow them to support a family. Furthermore, teens who are parenting today usually have access to programs and services that lessen the negative impact of early parenthood and thus improve outcomes for both the mother and child.

A majority difficulty is finding an appropriate control group for teenage mothers and there has been a lack of consistency in who is chosen as a control (Oz & Fine, 1988). Studies often compare teen parents with groups that are sociodemographically very different (e.g. students in school, girls requesting contraceptive information at a clinic, pregnant girls awaiting abortion, non-pregnant teens, and adult mothers) so the studies are flawed by an inadequately matched comparison group (McAnarney, 1985; Oz & Fine, 1988, Parks & Arndt, 1990). Another limitation is that the majority of research on teen pregnancy has been conducted in the United States. There is little Canadian research especially at the national level. Schlesinger (1979, 1986)

provides an overview of research studies in Canada. Too often, American findings are taken at face value assuming they also apply to Canadian teenage mothers. Although we are strongly influenced by the United States and have many similarities, there are also major differences. Our health and social support systems are very different and may influence pregnancy and life outcomes of adolescent mothers. In addition, American research on teen mothers often highlights differences between whites, blacks, and other ethnic groups. Ethnic differences in the United States have nct been as relevant in Canada, where ethnic diversity has been mainly amongst Caucasian populations until recently. Ongoing research is needed to confirm or refute earlier findings and examine new trends. It is evident that more research on adolescent pregnancy and parenting in Canada is needed.

Unresolved Issues

Teen pregnancy and parenting has been studied for decades, yet there are no definitive answers on many issues. Two fundamental issues are still being debated: (1) whether parenthood is intended or not, and (2) the nature and extent of adverse effects of teenage childbearing. A brief summary of the controversies surrounding these two issues as explored in Furstenberg (1991) is presented.

There is conflicting evidence on how often teen pregnancies are intended. Survey data consistently indicate that teen pregnancies are usually unplanned and unwanted, yet more probing ethnographic or qualitative studies find that teens and their families respond favorably to an "unplanned" pregnancy. Leon Dash (1989), a Washington Post journalist, conducted repeated interviews with black teen parents. Although they initially denied

wanting to get pregnant, many later admitted they did desire to become pregnant. A recurring theme in Oz & Fine's (1988) interviews with teen mothers in Ontario was that they did not plan to get pregnant, but they were happy to discover the pregnancy. Pregnancy was seen as a rite of passage into adulthood and likely an escape from an unhappy childhood. For many girls an unplanned pregnancy is not viewed as a disaster but as an opportunity for direction, purpose, elevated status, and independence.

Many people find it difficult to believe that teen pregnancies are unplanned given that the majority of teenagers understand the relationship between intercourse and pregnancy and have access to contraceptives. For many people, teens' lack of effort to prevent pregnancy points to motivation or desire for pregnancy. Although teens are inconsistent and ambivalent in their responses about pregnancy, it is unlikely that many teens consciously decide to get pregnant. They are more likely focused on the moment, than plotting to get pregnant. Furstenberg (1991) says that if teens had to take some action—like take a pill—in order to get pregnant very few teens would. Teens realize that they could get pregnant, but their mystical thinking allows them to distort their chances, and risk taking is rampant during the teen years. Sexually transmitted diseases and AIDS are a risk of sexual activity, yet few people would say that teens who contract them are choosing to do so. Once pregnant, many teen girls let parenthood happen because they do not like their other options.

In the past adolescent childbearing was portrayed as having dire consequences; however, revisionist scholars, Kristin Luker and Arlene Geronimus (cited in Furstenberg, 1991), state that adverse effects have been

greatly exaggerated. They argue that teenage mothers are disadvantaged before they ever become pregnant, and when this selectivity is taken into account the affect of early childbearing is minimal. According to them, teenage parenthood is an adaptive response to poverty in that it is a way for teens who have limited opportunities to succeed.

Teenage parenthood does not happen randomly; teens who become parents at an early age are different prior to becoming pregnant than those who delay childbearing. Preexisting factors such as social background, schooling, family influences, and personal differences in cognitive abilities and motivation have an effect on early parenthood. The sequence of decisions that leads to parenthood results in "selective recruitment". Those teens who become mothers are "more likely to have grown up in extreme poverty, to have a background of family instability, and to have encountered academic and social problems in school" (Furstenberg, 1991, p.132). Studies that have tried to control for background factors have found that preexisting difference do account for a large part of the presumed consequences of early childbearing but not all the effects. For example, Geronimus & Korenman (1990) found little difference between teen and later childbearing sister pairs in relation to high school completion and income; however, later childbearers were more likely to be currently married and to have received education beyond high school.

Therefore, it is unlikely that adolescent parenthood causes disadvantage; teen mothers would likely have been disadvantaged even if they had not born a child during their teenage years. This does not mean that earlier childbearing has no effect. It would obviously be easier to rise above

disadvantage without the additional burden of early parenthood as suggested in the following quote:

> "...the disadvantaged individual must be extraordinarily committed to achievement in order to overcome the barriers created by limited opportunities, rigidities in the social structure, and discrimination. The socially advantaged need only be motivated; the disadvantaged must be super-motivated. Of course few of them are." (Furstenberg, 1976, p. 221)

Furthermore, teenage childbearing affects more than just the teen mother. It also has consequences for the child, the father, and the extended family. Even after "selective recruitment" to early parenthood, the outcomes of young mothers are quite diverse. The following quote suggests that there are mediating factors influencing the ability of young girls to successfully deal with the challenges of early parenthood:

> It is likely that the timing of first birth has minimal effects on the segment of teen parents who are extremely poor before the birth of their first child (though it may well have adverse effects on their offspring). Also, early parenthood may have only modest effects on the most capable women, who possess the resources to respond to the added demands of childcare. The burden of early parenthood might well be greatest for those capable of attaining economic self-sufficiency but lacking the resiliency to respond effectively to additional stresses. (Furstenberg, 1991, p.137)

Review of Relevant Qualitative Studies

Teen pregnancy is a complex issue and understanding of the issue cannot be obtained from quantitative studies alone. Although they can provide useful and necessary information, quantitative studies are only a piece of the picture. Qualitative studies are needed to provide a deeper understanding and more holistic perspective on teen pregnancy. Only qualitative data can convey the context and complexity of teenage mothers' lives.

Unfortunately, the majority of studies on teen pregnancy and parenting have been quantitative in nature. For example, Biddle (1995) reported the ratio

of quantitative to qualitative journal articles to be 5 to 1 in her literature review and Biscaro (1996) reported finding no studies that specifically asked adolescent mothers for their views of their experiences and desires for support. In the search of the four databases listed previously in this literature review only a handful of qualitative studies on adolescent motherhood were found; however, about a dozen unpublished theses and dissertations that used qualitative research methods to study adolescent mothers were identified. A brief overview of the existing qualitative studies will be presented next.

Four published articles were found where qualitative methods were used to study adolescent motherhood. In two of these studies, qualitative methods were only part of the study. Thompson et al. (1995) used semi-structured interviews and two standardized instruments in a follow-up study of adolescents who used perinatal services from a university hospital-based multidisciplinary program. The sample consisted of 19 of 98 mothers who could be located, and two-thirds of the subjects were black. The researchers looked at outcomes such as school completion, child development, and maternal perceptions. In another study, Flanagan, McGrath, Meyer, & Garcia (1995) used grounded theory to generate a hypothesis about developmental influences on the experience of mothering, then the hypothesis was tested using a quantitative method.

The third study used an open-ended interview format to explore the strengths of teen mothers and how they perceived themselves (Arenson, 1994). Seven participants, five white and two Hispanic, from a pediatric clinic in Colorado were interviewed. Arenson found that despite a chaotic past, teen mothers were committed to their children and to creating a secure future. The

adolescents also described how having children had a positive effect on their lives.

SmithBattle (1995) conducted a study using interpretive-phenomenological methods to look at how young mothers describe their past, present, and future. She interviewed sixteen mothers between the ages of 14 and 18 and spent time observing them in their homes. The sample included nine white and seven black teenagers, five of whom had dropped out of school, six were in school, and five had completed high school. Three different types of narratives were found. For one group, mothering did not engender a new future because their chaotic past already constrained them to a diminished future. A second group, also had an impoverished past, but they had at least one person in their lives who was caring and responsive. Having a baby was a catalyst to transform them and refocus their lives. A third group had stable, healthy families and educational ambition, but they were ambivalent about getting pregnant. Once pregnant they still had good family support and continued to do well.

Much of the qualitative research on adolescent parenting is in unpublished theses and dissertations, which are difficult to access. Seven American studies will be briefly mentioned followed by three Canadian ones. In 1988, Herr conducted an ethnographic study where she spent six months in an urban high school and interviewed 24 pregnant and parenting teens to determine how they perceived and made meaning out of their pregnancy and non-use of contraception. Two years later, Elise (1990) used grounded theory to examine the routes to teenage motherhood among African Americans, Native Americans, and European American teens. In 1995, Roth interviewed

young mothers to determine the role of school experiences in school attainment. Also in 1995, Biddle conducted an ethnographic study of the everyday lives of (mostly black) teenage mothers in schools that either had a special program or a nursery. She conducted interviews, did home visits, attended agency meetings, and had discussions with various school staff in an attempt to understand the teen mothers, the "voices" influencing their lives and the significance for social and school systems' policy. One year later, Guthrie (1996) did a case study on four teenage mothers to determine what they think, value, and look forward to and how the school could create positive alternatives to pregnancy. In the same year, Biscaro (1996) interviewed three adolescent mothers between the ages of 14 and 16 who were on social assistance to explore the meaning of their lived experiences. In 1997, Dolezal contrasted the personal narratives of adolescent mothers with the portrait of the pregnant teen in society and examined school reform.

As for Canadian studies, Hardy (1993) interviewed four students from a school for pregnant and parenting teens in Edmonton, Alberta about their educational and occupational aspirations. She found that the girls had educational and career plans; they believed that having a child motivated them to attain these goals, yet at the same time their children would make it difficult to reach their goals. In 1994, MacBean investigated the support systems of unmarried teenage mothers in Regina from a phenomenological orientation. She found that the teen's most meaningful support came from her family and the child's father or her male partner. A year later, Sundby (1995) interviewed eleven adolescent mothers to determine their perceptions and experiences with prenatal classes. She found that adolescents' learning needs were different

from adults. Adolescents only wanted information that was immediately relevant, and they preferred teaching strategies that were visual or hands-on.

Two other Canadian studies were reviewed. One was an older study conducted by Sacks, Macdonald, Schlesinger, & Lambert (1982) in Toronto. They did a descriptive study of problems, needs, supports, and outcomes of 50 adolescent mothers. A more recent study by Perry & Grew (1993) in rural eastern Nova Scotia had very similar objectives to this present study. They interviewed eleven pregnant teens (twice during pregnancy and once postpartum) to determine their perceived needs and concerns and the adequacy of services available. The participants ranged in age from 16 to 19 years old, almost two-thirds lived in a home where their father was present and were financially supported by their parents. Nine girls were in high school and two had dropped out prior to their pregnancies. The participants' main concern and need was financial resources; they were also concerned about their babies' health and staying in school. The majority of the babies' fathers helped out financially and most fathers were involved in childcare.

A number of researchers have attempted to increase our understanding of teenage pregnancy and parenthood through qualitative studies; however, there are still many gaps in the research. Just as with quantitative research, the majority of studies have taken place in the United States and have focused on cultural groups. As explained earlier these studies may not be applicable to Canadian teens. Many of the descriptive studies that have been done in Canada were conducted in the early 1980's (Macdonnell, 1981; Sacks et al., 1982, Calgary Social Services, 1985). Two recent studies by Hardy (1993) and Sundby (1995) have had a narrow focus, respectively educational aspirations

and perceptions of prenatal classes. Perry & Grew's (1993) study was conducted in rural Nova Scotia and the needs and concerns of this population may be different than urban teens in another province. In addition, one postpartum visit was inadequate to learn about parenting concerns and needs. The researchers claimed that their study used a collaborative and participatory process, yet their only method was structured interviews which is not collaborative nor participatory. Furthermore, the interviews covered 45 to 58 questions in approximately 45 minutes, which gave little opportunity for the participants to respond with more than a few words.

There is a lack of qualitative research in the area of teen pregnancy and parenting in general but especially in Canada. To truly understand the lived experience of the teenage mothers there is a need for more holistic and contextual research. Research has tended to focus on easily accessed populations such as students or clinic clients, studies of hard to reach populations such as school dropouts are lacking. In summary, a paucity of research exists on the perceptions and experiences of teenage mothers especially subgroups such as school dropouts. This research will attempt to address this gap and provide depth and breadth to the understanding of the lived experience of teenage mothers.

Reflections: We Know So Much Yet So Little

I found exploring the literature a daunting and overwhelming task. The first issue I faced was which databases to search. Teen pregnancy is a topic of interest in many disciplines (medicine, nursing, education, psychology, and sociology), and each discipline has a wealth of published literature. For example, from 1985-1998 there are over 1500 articles on the topic of teen

pregnancy referenced in MEDLINE, 1000 in ERIC, and 1100 in PSYCINFO. Despite the enormous amount of literature, I had difficulty finding Canadian articles. When Canadian articles were found, I was dismayed that most of the reported statistics and references were American in origin. For example, Hechtman's (1989) review on teenage mothers published in the Canadian Journal of Psychiatry starts by citing American rates of teen sexual activity. Only one of the 53 references was clearly Canadian, and it was an unpublished manuscript.

Furthermore, many statements made in current literature are based on research studies from the 1970's and early 1980's. We do not know if these findings are still valid for teens in the 1990's. There was a lack of current statistics; they all seemed to be 2 to 4 years behind. For example, Wadhera & Millar's 1997 publication on teen pregnancy in Canada only had figures up to 1994. Even local statistics from the Capital Health Authority's 1996 report were based on 1993-94 figures. How valuable is research that uses old figures? Despite all the research there are still so many unresolved issues. The many factors that lead to teenage pregnancy are hard to sort out, and it is almost impossible to separate the effects of early parenthood from individual and family differences and socioeconomic status. In the end, we have a lot of data on teen pregnancy but know little. Hopefully, this study will be another piece in the picture of teenage pregnancy and parenthood in the Canada.

Chapter III

METHODS

Rationale for Qualitative Methodology

Qualitative research is interpretive, naturalistic, and inductive. It is a multi-method approach with an emphasis on processes and meanings. Qualitative researchers believe that reality is socially constructed, context is part of the phenomenon, and closeness to the subject is required. These researchers study phenomena in their natural settings and try to understand the meaning people give to experiences in order to describe and explain phenomena and develop explanatory models or theories. Close, interpersonal relationships are necessary to gain this meaningful insight into people's lives.

Qualitative research does not begin with a hypothesis but rather allows hypotheses and theories to emerge from the data. This requires setting aside one's assumptions and knowledge of the phenomenon. Even so, no researcher enters a project *tabula rasa*[2] (Sandelowski, 1993); every person has his or her own history, perspectives, and biases. It is important for the qualitative researcher to recognize his or her subjectivity and reflect on his or her interpretive processes.

The nature of the research question determines what research approach and design to use. Qualitative inquiry usually answers questions about what an experience is like for individuals. This approach is the method of choice when little is known about a phenomenon or when the goal is to explore issues from the insider's perspective (Morse & Field, 1995). The purpose of this study was to explore the experiences of teenage mothers who had dropped out of school.

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[2] As a blank slate; with no biases.

The decision to choose qualitative methodology was based on the fact that little is known about this subgroup of adolescent mothers especially regarding their views and perceptions of their experiences. Furthermore, teen pregnancy and parenting is greatly influenced by social context and the constraints of everyday life; therefore, it was important to capture context as part of the phenomenon. It was believed that a rich description of the teenage mother's world and events as she experiences them would be of value to the many professionals that work with pregnant and parenting adolescents as well as to society in general.

Ethnography: An Overview

The method of research chosen for this study was ethnography. Ethnography is any full or partial description of a group of people who have something in common (Boyle, 1994). It involves observing and participating in a particular culture over an extended period of time (Spradley and McCurdy, 1972). Traditionally, anthropologists used ethnography to describe primitive or small-scale societies. The current trend is to use ethnographic methods to study any social unit, subgroup, or subculture within urban society. Morse (cited in Boyle, 1994) used the term "focused ethnography" to describe topic-oriented, small group ethnographies.

Although there are different types of ethnographies, they all have common characteristics. Ethnography is based on cultural theory, which assumes that culture is learned and shared among members of a group (Boyle, 1994). Participants belong to a culture or sub-culture through shared norms and language from a common experience, which in this case is being a teenage mother who has dropped out of school. Ethnographies are holistic, contextual,

and reflexive. The ethnographer learns *from* people by placing himself or herself in the environment of the informants and becoming directly and personally involved with them as they go about their everyday living (Morse & Field, 1995). The goal is a well-rounded understanding of the group in their natural environment, which requires prolonged and direct contact with group members. The process always includes a combination of participant observation and conversation or interview; and it is the interplay between these two activities and the dual insider/outsider views that leads to insight or reflexivity. The aim is to describe "culture" from the emic perspective or insider point of view; therefore, the data are often presented in narrative form "letting the informants speak for themselves" using both their words and behaviors for support.

Reflections: Research Methods

Ethnographic methods were chosen for this study because the purpose of ethnography and the data collection methods associated with it fit with the needs of this inquiry. The research methods used in this study most closely fit the characteristics of a focused ethnography. It was an exploratory study with a small group of informants and data were collected using unstructured and semi-structured interviews and selected episodes of participant observation (Muecke, 1994). Informants were chosen primarily because they had knowledge or experience of interest rather than because the researcher had developed a relationship with them. The study was also context specific and problem-focused, although it explored more than one problem. The needs and issues of a particular group in a particular city were studied with the primary

purpose of gaining knowledge and understanding that could add to the literature and also improve professional practice.

When the study was proposed, my supervisors felt that there would not be enough opportunity for participant observation to deem the study a focused ethnography; therefore the study was labeled an exploratory-descriptive study using ethnographic methods. However, my involvement with a young mothers support group granted many opportunities for social interaction over an eight month period with a number of pregnant and/or parenting young women. My observations focused on a core group of four young women. The observations, although not systematic, allowed me to gain greater insight into their day-to-day experience from a variety of vantage points. I was able to observe these women with[3]:

- each other during the group,
- each other outside the group,
- newcomers or drop-in moms,
- the facilitators and other professionals,
- their friends who were not in the group,
- their boyfriends,
- members of their family, and
- Pastors and other church members.

As well, there was also the interaction the women had with me, one-on-one or within a group. This level of involvement with the young women in the support group was not anticipated, but it greatly enriched the study. The time I spent with these young mothers was not formal observation nor was it

[3] I did not observe all the women in all the situations.

structured; however, it was an opportunity to see them in their natural environment. Afterwards, I would reflect on my time with them and would integrate their words and actions into my emerging understanding of their world: "much evidence for comprehension is accumulated in unscheduled, informal ways" (Agar cited in Muecke, 1994, p. 191).

Being a participant and an observer in a group has benefits and challenges. Participant observation requires some level of involvement in the lives of the people under study (Boyle, 1994). "Without, close, empathic, interpersonal interchange and relationship, researchers will find it impossible to gain meaningful insight into human interaction or to understand the meaning people give to their own behavior (Maguire, 1987, p. 20). There were many benefits to my ongoing participation in the lives of young mothers. I was able to observe their interactions with a variety of people in a number of settings. This helped me validate interview data, gave me insight into their everyday lives, and allowed me to see how their lives changed over time.

Ongoing relationships with the women also presented challenges. Developing and maintaining relationships required a lot of "hanging out" and sometimes lengthy phone conversations, which was time consuming. We had many conversations in which ideas, beliefs, and experiences were discussed. I shared in these conversations; however, I was conscious not to direct the conversation and was respectful of their beliefs. Although they never asked me to, sometimes I paid for the drinks and food knowing that they were short of cash. In some instances, participants did ask to borrow money. For example, one woman asked me to pick up a "pack of smokes" for her and another time she needed a few dollars to fill a prescription. Some researchers may disagree

with "lending" money. However, the women in the group often helped each other out lending a few dollars, offering cigarettes, or sharing resources such as children's clothing and babysitters. As part of the group, I felt comfortable with lending/giving small amounts of money or sharing my resources such as transportation or knowledge, but I was also aware of my limits. However, there was one situation in which I was uncomfortable. One of the women got pregnant shortly after giving birth. She told me that she had decided to have an abortion although she knew that I did not agree with abortions.[4] It would have been unethical of me to try and influence her decision. I asked if she was sure she wanted to have an abortion and if she had considered all of her options. Then, I said it was her decision and that whatever she decided would not affect our friendship. She went through with the abortion a few weeks later; it did not impact our relationship. Direct personal involvement with people during research is exciting, rewarding, insightful and, of course, challenging!

Research Design

This study was a small group or focused ethnography. Ethnographic interviews, informal observations, and focus groups were conducted to collect data to answer the research question. Participant selection, interviews, and data analysis occurred simultaneously. Interviews and fieldnotes were read for common concepts and themes, then the relationships between concepts and themes were examined. I described and analyzed the data to provide insight into the beliefs, practices, and experiences of young mothers.

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[4] Abortion had been discussed on more than one occasion during our coffee sessions and she knew my Christian beliefs did not support abortion.

I conducted a practice interview with one volunteer participant who met the inclusion criteria. The interview was tape-recorded and reviewed by my thesis supervisors for feedback on improving interview technique. My supervisors and I decided that the interview style and skill was satisfactory and formal interviews began. The practice interview did not differ significantly from subsequent interviews, therefore it was included in the analysis.

The Participants

Interview participants were comprised of a purposeful convenience sample of pregnant and/or parenting adolescent girls who volunteered to be interviewed. The focus group was conducted with a group of pregnant and/or parenting adolescent girls attending an outreach school. Informal observations were completed with a group of young mothers who attended a support group. Only interview participants were screened for inclusion criteria. Participants were chosen because they had knowledge or experience of the phenomenon under study and because they would be "good" informants (articulate, reflective, and willing to share with the interviewer) (Morse, 1989). As the study progressed, participants were selected according to the specific informational needs of the study.

Sample size was not predetermined but decided by data adequacy (Morse & Field, 1995). Adequacy is determined by "the relevance, completeness, and amount of information obtained" (Morse, 1989, p. 123). Sampling occurred concurrently with interviewing and analysis, and it continued until saturation was achieved (that is, when there were no new data emerging). First, seven participants were interviewed; six of them were interviewed more than once to trace patterns of change over time, discover further information, or clarify

previous information (Hammersley & Atkinson, 1995). Then, the sample was expanded from 7 to 13 participants by conducting a focus group. This allowed for more diversity in participants and was a method of validating interview data.

The seven interview participants were recruited using a variety of methods. Four participants were recruited from members of the support group at which I volunteered; therefore, there was already a level of rapport and trust established. Three girls responded to advertisements (Appendix B) put up in outreach schools but only two were interviewed. The third girl did not arrive for the scheduled interview and the interview was not rescheduled because I discovered that she lived outside the Capital Health Region. This same girl, however, ended up being in the focus group. One girl was referred by an agency, and I went to speak to the girl at her school assuming that the staff had already mentioned the study to her. The girl had not been informed of the study; however, after explaining the study to her, she agreed to participate and an interview was scheduled for the following week. She did not appear for the interview so it had to be rescheduled.

Selection criteria for inclusion in the study were:

1. 15 to 19 year old female,
2. pregnant or parenting one or more children,
3. had dropped out of school (at some point),
4. able to speak and understand English,
5. resident in the Capital Health Region, and
6. able to commit at least 3 one hour time periods for interviews.

The age criteria were not strictly adhered to in selecting the participants. One woman who had just recently turned 20 years old was included in the sample for three reasons. One, she was a high school dropout; two, she was on social assistance; and three, she was 8 months pregnant and I wanted to follow her through her postpartum period to discover how she coped and how she used services. Although my original intent was to recruit adolescent mothers who were currently school dropouts only two of the participants were not in school at the time of the study. The remaining eleven all had a history of dropping out, but they were currently attending school. In retrospect this mix of participants was valuable as it allowed me to explore the difficulties teenage mothers encountered in returning to school and it provided an opportunity to examine the temporal sequence of pregnancy and dropping out.

Data Collection

Interviews

The main data collection method was semi-structured interviews with open-ended questions (Appendix C). Interviews were crucial as they allowed the participants to report their perceptions and experiences. The interview guide consisted of questions and prompts organized in five different themes (pregnancy, parenting, services, school, and future). I developed the interview guide based on the research questions, relevant literature, and questionnaires or interview schedules used in other studies (Arenson, 1994; Perry & Grew, 1993). Semi-structured interviews allowed me to maintain some consistency during interviews, yet they still allowed participants enough freedom to focus on what was important to them. The questions were useful in sparking conversation and the flexibility of question order enabled the participants to

tell their stories without too much interruption. Flexibility was important as the participants and their situations were quite diverse and sometimes complex.

Thirteen interviews were conducted with seven participants over an eight-month period. All the participants appeared comfortable and relaxed and shared openly except the one girl who was referred. She was very shy and gave only brief answers to direct questions. Six of the participants chose to have the initial interview at a restaurant and one chose her home. Two of the participants were met at a restaurant of their choice and two were met at school before proceeding to a restaurant together. One of the interviews was done in a fast food restaurant with a woman and her two young children. It was noisy and there were many interruptions from the children. I picked up one of the participants at her home then drove to a restaurant where we had lunch followed by the interview. I brought "take-out" to the interview conducted in the participant's home and had lunch with the young woman and her toddler before the toddler had a nap and the interview was conducted.

The interviews had an informal and friendly atmosphere and were 45 to 90 minutes long. At the beginning of each interview the study was explained and informed consent was obtained (Appendix D). Background data were then collected from each participant so that the study sample could be described regarding participants' demographic characteristics, current context, and past experiences (Appendix E). Collecting this information at the beginning of the interview was helpful in breaking the ice, placing their story in context, and identifying areas to explore further. Finally, the interview was conducted using

the interview guide. After reflecting on the first interview, two questions were added under "services" (Appendix F).

Initially, I began the interview by saying "Tell me what it has been like as a young mom". It was found that either the women did not know where to begin or that they began their story, but they had to keep backtracking to explain important background or contextual information. I began asking about their pregnancy first to get the story started. The interview guide was officially modified after the fourth interview to begin with questions about their pregnancy (Appendix G). This format resulted in a smoother conversation as participants told their stories chronologically from when they suspected they were pregnant to the present. Sometimes it was still necessary to ask specific questions to elicit contextual data. Many of the participants' lives were very complex so in some cases a timeline was created to assist in sorting out the details.

Although the setting was not always ideal, as there was considerable background noise, all interviews were tape-recorded. Although some recordings were noisy, they were understandable. I tried to find a quiet, more secluded spot in a public setting, but participants chose the location and did not appear concerned that others might overhear the conversation. Fieldnotes were written after the interview to record contextual data such as the setting, participant's nonverbal communication, and interruptions. Few, if any, notes were written during the interview as it was distracting to both the participant and myself. Any relevant information from comments or conversations after the interview was also recorded in the fieldnotes. Each interview was

transcribed verbatim either by a transcriber or myself. All interviews transcribed by the transcriber were reviewed for accuracy.

Observations

Participant observation is essential in ethnography (Boyle, 1994; Morse & Field, 1995). Observations focus on the context and the reactions of participants in social settings. As explained earlier, I had the opportunity to observe members of a young mothers support group in a variety of situations. There are different types of participant observation: complete participant, participant-as-observer, observer-as-participant, and complete observer (Morse & Field, 1995). I had been a participant in the support group and later became an observer; thus, was positioned as a participant-as-observer. This role was appropriate because not all interactions and conversations were relevant. As four members of the support group also took part in interviews, observing them in their natural setting helped me validate, interpret, and enrich interview data. Fieldnotes comprising relevant conversation, comments, behaviors, and impressions were recorded as soon as possible.

Two concerns with observations in this study were informed consent and losing objectivity ("going native"). Although members of the support group were aware of my dual role as both participant and researcher, trust was quickly established and relationships developed on a more personal level. I tried to remind the support group during check-in of my dual role by discussing the study or research activities. During conversations, I made reference to the research and the value of their comments and insights to the study. Sometimes very personal information was disclosed. In these instances, I specifically asked permission to include this information in the study.

I had already achieved entry into the support group when the study began. The setting was familiar, which helped to reduce the level of strangeness, and the participants were already comfortable with my presence. Data become richer as the researcher-as-stranger develops into researcher-as-friend, but this also increases the risk of 'going native' (Leiniger, 1985). As time passed, the participants' words and behaviors were less shocking to me, and I empathized with them more. However, I could still pull myself back and look at the situation more critically or from an outsiders (etic) point-of-view.

Focus Group

A focus group was conducted after the initial interviews to validate interview data, increase sample size, and make the sample more representative and diverse. Six pregnant or parenting teens from an outreach high school took part in the group. The outreach high school was located in a mall and catered to students who had dropped out of regular pubic high school. A family support worker (FSW) came to the school once a week to deliver a prenatal intervention program, which included free milk coupons. She also conducted classes or sessions in which teen parents could participate and receive credit. I attended the last session of their parenting class and the planning session that the FSW had with the teens about their next class. At the end of this planning session, I asked the teens if I could talk to them after their next session about their experiences as teenage mothers.

The focus group was conducted during lunch hour after the group's first session on family dynamics. Both my assistant (who took notes during the focus group) and I participated in the two hour session prior to the focus group. After the session, the study was explained and informed consent was

obtained from all participants (Appendix H). The teens filled out background information forms, (Appendix I) then they took a smoke break. When they returned, the teens had pizza and pop, which I provided. While they ate, I began the discussion asking similar questions to those developed for the one-on-one interviews (Appendix J). The group was already comfortable with my assistant and me because we had participated in the session and even shared details about our families and ourselves. The teens were relaxed and talkative from the beginning. The focus group, which lasted approximately an hour, was tape-recorded and later transcribed.

Data Management

Qualitative research yields a tremendous amount of data; thus, an effective method of organizing data for ongoing analysis and interpretation is essential. In this study, a number of strategies were used to organize and sort the data. All data including transcripts, methodological memos, fieldnotes, and journal entries were dated and cross-referenced. Interview text was copied from a word processing program into a spreadsheet program and line numbers, a code name, and interview number were added so that quotes could be traced back to the original source. Category codes were entered alongside the interview data in the spreadsheet program. Interview text from all participants was pooled and sorted according to category code and participant. This procedure automated the traditional cut and paste method and saved time.

Data Analysis

Data analysis took place concurrently with data collection. Strauss (1987) states that there are no set rules that govern qualitative research and analysis. However, simultaneous data collection and analysis allowed for

validation and clarification of categories as they emerged. In this study, the cognitive processes (comprehending, synthesizing, theorizing, and recontextualizing) outlined by Morse (1994) guided the analysis. The goal was to identify patterns, commonalities, or themes in the data and try to understand them. Although some commonalities in the data were obvious others were not identified until I was immersed in the data through repeated reading, constant comparison, and reflection.

The first step in analysis was to comprehend or "make sense" of the data. A line-by-line textual analysis of each transcript was done to code the data. Coding involved using concepts to label words or phrases (Boyle, 1994). As each successive interview was analyzed and pooled together with previous interviews, similar concepts and commonalities began to emerge. Since the focus of the study was the experiences of teen mothers, categories tended to group around common subjects like "services", "concerns", "needs", and "school". Themes revolving around their perceptions also began to be evident. Categories and sub-categories were added in an attempt to develop a coding system that captured the richness and breadth of the data.

The second step was to pool and synthesize the data into an aggregate story that described the common experiences of the group and differences among participants. A question by question summary of all interviews was completed to aid with comparisons. This process helped me integrate the data and identify common experiences or beliefs that had not been previously evident. The participants were diverse in both background and circumstance, but many aspects of their experiences were similar. When no new data or categories were emerging, the data were said to be saturated. My fieldnotes

and journal entries were also part of the data analysis. Thoughts, ideas, and reflections regarding the data and emerging categories were noted and reviewed to assist during the data analysis process. Direct quotations from participants are used to illustrate their stories and the common themes that emerged from their stories in the following chapters.

The third step, theorizing, was a sorting process that gave data structure and findings application. Through "an active, continuous, and rigorous process of viewing data as a puzzle", the "best comprehensive, coherent, and simplest model for linking diverse and unrelated facts in a useful, pragmatic way" was discovered (Morse, 1994, p. 32). The structure or framework for the data in this study was developed through inductive reasoning and lateral thinking. All the pieces of data were examined for what they had in common and how they fit together to form a larger picture.

The final step of analysis was recontextualizing. The emerging theory links new findings to established knowledge, and this established knowledge and theory provide the context in which to fit new findings. It is "the theory that is generalized and recontextualized into different settings" and applied to other populations (Morse & Field, 1995, p. 129). The results of this study are discussed in relation to the model that was developed and in the context of existing knowledge on teenage pregnancy and parenthood. Findings that support existing knowledge and theory are identified and new contributions are outlined.

Research Standards

Rigor is essential in all research to ensure that results are trustworthy. The concepts of reliability and validity are important in evaluating quantitative

research. Qualitative research, however, is fundamentally and philosophically different, so these concepts have been replaced by evaluation standards. Guba & Lincoln (cited in Sandelowski, 1986) describe four criteria that can be used to evaluate qualitative studies. They are credibility, applicability, consistency, and neutrality.

Credibility

Credibility, the valid representation of the truth as perceived by the participants, is one of the most important criteria in qualitative research (Leiniger, 1994). The findings are true or credible to the degree that they report the perceptions and experiences of participants. The greatest risk to truth-value is that the boundaries of the study will be too narrow and will unknowingly exclude what is relevant to the participants (Morse, 1994).

Several strategies were used to ensure credibility. A semi-structured, open-ended interview format was chosen so participants had the opportunity to discuss what they believed was relevant and important. Participants were recruited from a variety of sources to reduce bias and context-dependent factors. I established rapport with and gained the trust of participants, so that they shared experiences freely. Conducting participant observations also enhanced credibility (Morse & Field, 1995). I observed a number of participants in a variety of situations over a period of time, which increased the accuracy of the interpretation of the data.

Follow-up interviews were conducted when necessary to obtain additional information and to verify earlier responses. Member validation occurred when verifying data in follow-up interviews and with subsequent participants. Other measures to ensure the credibility of the data included recording contextual

data, checking transcripts for accuracy, and using participant quotes to illustrate concepts.

Applicability

Applicability of the qualitative research is evaluated by representativeness of the data and fittingness. Subjects may not be representative due to small sample sizes and theoretical sampling; however, the data should be representative of the phenomenon. Data were assessed for both quality and sufficiency. This study used a variety of recruitment methods in an attempt to recruit even "hard to reach" members of the group. A focus group was conducted to increase the representativeness and adequacy of the sample. Sampling continued until data were becoming redundant and the categories were saturated. To ensure that findings fit the data and reflected the experiences of participants, data were validated with the participants during later interviews or with other participants. My coding and analysis of initial interview data were compared with that of my thesis supervisors to ensure data were accurately represented.

The findings not only have to "fit" the data from which they were derived, but they also should "fit" into other contexts or settings. "The transferability criteria focuses on general similarities of findings under similar environmental condition, contexts, or circumstances" (Leiniger, 1994, p. 104). The context of this study was clearly described and delineated to help the reader determine whether the findings are applicable in another setting or within another group. The reader determines the usefulness of the study and its findings.

Audibility

Repeatability is not essential in qualitative studies (Sandelowski, 1993); however, findings should have a level of consistency or dependability. The research procedure was outlined in detail including the interview guide used. Interview tapes, fieldnotes, methodological memos, and a personal journal were kept. Both the research methods and findings are available for review. Other researchers should be able to follow this "decision trail" and come to comparable conclusions.

Confirmability

Neutrality in qualitative research refers to the findings not the researcher. The findings should "objectively report the perceptions of each participant in the setting" (Morse & Field, 1995, p.142). Subjectivity was recognized and valued in this study through my involvement with participants and in the emphasis on the subjective reality of participants. If findings are trustworthy, individuals having similar experiences should recognize their experiences in the description or story told by the researcher. According to Sandelowski (1986) neutrality is confirmed when auditability, credibility, and applicability are established.

Ethical Considerations

Ethical Review

I received ethical approval for this research study from the Ethical Review Committee in the Department of Secondary Education in the Faculty of Education at the University of Alberta.

Informed Consent

Each participant, including focus group participants, were informed of the study's purpose, procedure, and time commitment, before they signed a written informed consent form (see Appendix D and Appendix H). Individuals were not coerced or pressured in any way to participate in this study. It was made clear that they were not required to participate in the study, they could stop the interview at any time, and they could refuse to answer any question. The readability of the consent form was checked using Microsoft Word and was at a fifth grade level.

Participants were asked whether they had questions or concerns about the study both before and after the interview. A few participants asked questions about the study such as "What are you planning on doing with all these interviews?" "How do you plan to try and help?" and "Will you need to see me again?" Most participants, however, asked personal questions like "Do you have any kids? Why not?" and "Are you married?"

Informal observations were conducted with members of a young mothers support group both during the group and afterwards in public settings. No written consent was obtained for such observations; however, individuals were made aware of the research. "Anonymous observation is ethically appropriate and defensible in public situations open to anyone, such as journalists" (Lipson, 1994, p. 347). The focus of observations were three young mothers who were also interviewed and had given informed consent. Participants were asked for their permission to use data collected from conversations outside the interviews.

Confidentiality

Participants were guaranteed that their identity would remain confidential. Only my thesis supervisors, the transcriber, and I had access to the raw interview data. These individuals agreed that information about participants would be kept confidential. All materials were kept in a secure filing cabinet when not being used. Informed consent forms were stored separately. Audiotapes, transcripts, and notes will be kept for seven years and consent forms will be kept separately and destroyed after five years as required by the Faculty of Graduate Studies and Research guidelines.

Anonymity

Only I knew the identity of the participants in this study. Code names were used to label all audiotapes, transcripts, and notes. All identifying information was removed from transcripts. In writing the results, care was taken to conceal identities by changing names or other identifiers where necessary. In reporting the results, excerpts of transcripts are only identified by a letter. Participants were made aware that interview data may be used for teaching purposes or secondary analysis but anonymity would be ensured.

Risks & Benefits

There were no risks to participating in the study and no incentives were used to elicit participation. Although no tangible benefits were promised, sometimes I bought the participants food or beverages. I also provided each participant with a list of community resources and emergency phone numbers after the initial interview. All information was kept confidential. The study gave participants a chance to help others understand their experiences and

have their concerns and issues heard. In addition, it is hoped that telling their story and being listened to helped to validate their experiences and self-worth. For example, one participant commented that expressing her dissatisfaction and being listened to made her feel better and helped her deal with an upsetting situation.

All but one participant wanted to receive a summary of the study results. The interested participants filled out their address on the study results form at the end of the informed consent so that I could mail them the results upon completion of the study (Appendix D).

Reflections: My Subjectivity

As a qualitative researcher, one tries to keep one's knowledge and assumptions "in abeyance"; however, this in no way means that one is objective. Objectivity is an illusion (Maguire, 1987). Everything a person encounters is filtered through his or her past experiences. Anything that could shape the researcher's understanding and analysis of the phenomenon should be made explicit including motives, background, and preconceptions in order to avoid imposing these biases on the data.

I chose to study teenage mothers and particularly those who dropped out of school for a number of reasons. I believe that parenting is the most important job because childhood experiences greatly impact the kind of adult that a child becomes. I also believe education is important for personal development, critical thinking, and economic success, yet many children do not value education and the situations of other children make it difficult for them to succeed in school. Too many children enter school not ready to learn, and many are tired, hungry, or abused. How can we expect them to learn? I see too

many children and teens falling through the cracks and not receiving the help and support they need. Health, education, and economics are all interrelated, but our society divides them into discrete sectors. The result is fragmented services and inflexible bureaucracies that leave many gaps in our social system. Teenage parents are one group who fall through the cracks. We need to better understand them and the systems they have to deal with so that we can take steps to help them.

In reflecting on my chosen topic, I was aware of a number of presuppositions or assumptions that I had about teenage parents. I believed that (1) teenage mothers who were not in school would be more isolated, (2) pregnancy would only be one of many factors leading to school drop out and often dropping out of school would precede pregnancy, (3) pressures of parenting would make it difficult to succeed in school especially a traditional school, (4) finances would be a major concern for teenage mothers living independently, (5) a feeling of loss would be expressed because pregnancy and parenting cuts one's adolescence short, and (6) a number of barriers to employment, using services, and achieving goals would be identified.

A middle-class upbringing shaped my experiences and a Christian worldview directs my values. I recognized that the opinions, values, and experiences of the women who participated in my study would likely be very different than mine. It was important not only for me to be non-judgmental but also for the women to know that I was not judging them. Being aware of my biases helped me keep them from influencing the data collection and analysis. Examining my own subjectivity and interpretive process was an on-going process throughout the research.

Chapter IV

CONTEXT

In order for an outsider to truly comprehend the teenage mother's experience, he or she must really know about the mother's whole world. This chapter is included to provide background on the participants' lives as their past experiences impact their present experiences. It is important that this chapter be read with the desire to understand where these girls are coming from rather than to be judgmental or critical of the girls' thoughts, behaviors, or families.

An adolescent's adjustment to motherhood is greatly influenced by the circumstances surrounding her pregnancy, current situation, and past experiences. In the qualitative paradigm, reality is believed to be socially constructed. The meaning adolescent mothers give to their experiences is influenced by their context—context is part of the experience. An in-depth understanding of the participants and the context of their lives also helps the reader make decisions regarding the applicability of findings to other groups.

The first part of this chapter is a summary of the participants' characteristics. Then, family background and past experiences of the participants are outlined. Next, the circumstances surrounding their pregnancy are explored followed by an overview of their school history. Finally, two common themes from the context data are presented. Differences and unique experiences are also noted. The essence of the participants' lives is illustrated using descriptions, observations, and verbatim quotes. Participants are only identified by a letter to protect their anonymity; their words are in bold. Before the contextual data are presented, I share a few of my thoughts.

Reflections: From Them to Me to You

I had the opportunity to spend a significant amount of time talking and "hanging out" with pregnant and parenting teen girls. Thirteen young women, between the ages of 16 and 20, took the time to share their experiences with me; three of them allowed me to become directly and personally involved in their lives. Unlike the average person who sees a teenage mother walking in the mall, a teacher who has a pregnant or parenting girl in his/her class, or a doctor who provides a teen with prenatal care, I had the opportunity to see teen mothers from an ecological perspective as whole persons in the context of their everyday lives.

The participants shared their lives with me, now I attempt to share them with you, which is not an easy task. Not only is it difficult to explain their complex lives, but it is also impossible to share all that I have learned and experienced with some descriptions, summaries, and a few quotes. It is important that you have some insight into the context of the girls' lives, yet I worry about how you will interpret the data. My goal is to help you better understand the world of teenage mothers, but I have no control over the attitude you have when they read about these girls. I hope that you will be able to let these girls' stories go through your mind and into your heart.

Characteristics of Participants

Seven women were interviewed individually and six took part in a focus group. A summary of participant characteristics is presented in Appendix K and pregnancy data are presented in Appendix L. Additional comments and explanations regarding participant characteristics are presented below.

Interview Participants

Seven participants between the ages of 16 and 19 were interviewed. At the time of the initial interview, five of the young women were parenting, one was pregnant, and one was pregnant and parenting. The ages of the participants' children ranged from two months old to two and a half years old. Participant A had two children. Three of the participants (A, B, and G) had had multiple pregnancies; however, not all of the pregnancies ended in a live birth.

Participant A was married, participant F was living common-law and the remaining five were single. Of the five single participants, participant B and G were living on their own, participant C was living with her parents, participant D was living with her baby's paternal grandmother, and participant E was living with a foster family. Three of the participants relied on one source of income: participant B on social assistance, participant E on an independent living program, and participant G on student finance. The remaining four received financial support from a combination of sources: participant A relied on her part-time earnings and her husband's income, participant C on parental support and student finance, participant D on child welfare and relatives, and participant F on student finance, child support, and part-time employment.

Five of the seven participants were currently attending school although all participants had dropped out of school for a period of time. Participant A had completed Grade 8, participant D had completed Grade 9, participant E and G had completed Grade 10, participant B and F had completed Grade 11, and participant C had completed Grade 12 and was upgrading. Both participants A and B who were not in school wanted to eventually complete high school.

Participant A had no immediate plans to return to school while participant B had returned to school for upgrading by the end of the study.

Focus Group Participants

In addition to the individual interviews, there were six teens from an outreach high school who took part in a focus group. Four of the young women were parenting and two were pregnant. The ages of their children ranged from 9 months old to 3 years old. All the participants had had only one pregnancy.

Four of the young women were single and two were living common-law. Participant K who lived common-law also lived with her boyfriend's mother, brother, and uncle. Participant M lived with her boyfriend and his parents. Both of these women relied on student finance and their boyfriends (plus their boyfriend's family) for financial support. Participants I and J lived on their own and were supported by student finance; participant L lived with her parents; and participant H with her mom and a roommate and she relied on parental support and part-time work.

All of the participants were currently attending school although all of them had dropped out of school for a period of time. They were all working on high school courses, but it would be inaccurate to say they were in a certain grade. Students all worked individually at their own pace on one or two courses at a time, so they could be working at basic Grade 10 level in one subject (e.g. Math 13) and an academic Grade 12 level in another subject (e.g. English 30). Participant M mentioned that she had already finished Grade 12 and was just upgrading.

Family Background and Past Experience

A summary of participant characteristics gives us a general picture of the study population, but it provides little knowledge of the participants' world as they experience it. The participants' world includes both past and present experiences. Four common characteristics relating to family background and past experience are explored: (1) single-parent or divorced families with elements of dysfunction, (2) unstable living situations, (3) early independence or lack of supervision, and (4) abuse.

Only two of the thirteen participants (C and L) grew up in intact, stable homes. The remainder came from families beset with divorce and single parenthood, and many participants described elements of dysfunction in their family. Eight of the participants' parents divorced—seven when the girls were just pre-schoolers and one when the participant was 12 years old. After the divorce, some girls stayed with their mothers (most of whom remarried), a couple of girls went back and forth between their parents, and one girl lived with her father. Participant A's father died when she was 7 years old and her mother remarried a couple of times. Participant D only saw her father briefly when she was very young. Her mother was a teenage mother, and **"she wanted to have her fun"** so the participant's grandmother raised her. Participant F said, **"Never had a dad, never. It was a one-night stand."** She was raised by a single mother; although, she has had little contact with her mother since she left home at age 13.

Participants not only had to contend with divorce and absent parents, but many girls also had to deal with other family problems. Two of the participants' fathers were alcoholics, one mother suffered from manic

depressive illness, and another mother was on Prozac[5] and had drinking episodes.

> [So why didn't you ever go live with your dad?] **Because my dad is an alcoholic and he gets very violent when he's drunk. If he's sober, he's the sweetest guy you'll ever meet. But he gets like 4-5 drinks into him and he starts turning the phone receiver upside down and singing the Mickey Mouse song. Kind of stupid but he's a nice guy and a very caring parent given, you know, that he doesn't always remember our birthdays. But he's got a lot of stuff going on. (E)**
>
> **I was having a lot of problems at home with my mom, dealing with my mom and her illness. And I couldn't concentrate on school. I just wanted to get out of the situation that I was in so I ran away. (A)**

One girl's baby weighed only 4 pounds 6 ounces when she was born. I asked if the baby was premature, her response illustrated some of the family problems.

> **I think her low birth weight probably had something to do with when I was living with my mom. She didn't have a job. You know the only income that we had was from Social Services. And when she would get the Social Services check, the first thing that she would go and buy was cigarettes you know or she'll go buy herself clothes or whatever. So we didn't really have much for food in the house. So I think her birth weight was probably something that had to do with I didn't have proper nutrition. (E)**

Some participants did not have good relationships with their parents as illustrated by their comments.

> **My dad hasn't seen my daughter since right after her first birthday, so it's been like five months, but that's fine with me 'cause I don't really like him. He's not the most honest person. He's very manipulative and stuff like that. So, no, it's mainly just my grandparents and my sister who are helping me out. (G)**
>
> [And your mom...] **Is a fat sow. I don't like my mother. She's very mean and very selfish and she only cares about herself you know. And if a situation ever came up where she'd either have to protect herself or protect her children, she would protect herself. That's how incredibly selfish this woman is. And she doesn't care who she has to screw around to get her own way. She'll go ahead and do so. She's a very mean woman. (E)**

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[5] A prescription drug commonly used for depression.

One of the participants from an intact family described a different experience with her family.

> **...he gave me a hug. And I just started crying. Like my dad has never hugged me that I can remember. And he's like "I love you and we'll get through this." Two weeks later he's like, I got baby books, I got this, I got that you know. And it was just so, seeing my dad with my daughter is—it's like a little kid. You know I've never seen my dad like that before...**[Who helps you with your child?] **It's my mom, my whole family actually. (C)**

Participant F made comments regarding her lack of family.

> **Never had a dad, never. It was a one-night stand. But, I don't want anything to do with my mom...Just my boyfriend. He's the only help. My family are gone. I don't associate with my family. So it's just my boyfriend's help.** [So how come you don't have any contact with your family?] **I never really did. When I was thirteen I left. And most of my family lives in the States too. Like, my grandma just died two years ago, and my grandpa died before that, so there wasn't really much family here. (F)**

Divorce created unstable living situations for many of the girls; they were often shuffled back and forth between parents. The following is a list of the living situations and family units experienced by participant G:

> both parents (until 7 years old)
> single mom with her 5 siblings (8-9 years old)
> single dad with one of her siblings (10-11 years old)
> mom, step dad, siblings, niece & nephew (12-14 years old)
> her boyfriend and her sister (15 years old); became pregnant
> dad & step mom
> mom
> on her own with her baby (16 years old)
> with friends
> on her own
> step dad and sister
> on her own (17 years old)

An ever-changing family/living unit was a common experience for a number of girls; four participants even had to live with friends or relatives for periods of time.

> **In between living on my own I lived with friends, family, relatives or wherever. (M)**

Some of the girls moved a lot because they were going from parent to parent or because their family moved frequently. Two participants dropped out of school: participant I in Grade 8 for two years and participant J in Grade 9 for five months. Their reason was **"moved around too much".**

Participants A, F, and M left home or ran away at age 13 or 14. These girls ended up living with boyfriends. When the relationship ended, they had to find a new place to live. Participant M who was living with her boyfriend at 15 years old ended up dropping out of Grade 10 for five months. Her reason was **"lack of self-confidence—lost a boyfriend",** plus she was moving around from relatives to friends just trying to find a place to stay. Participant B lived with three different boyfriends over a one-year period.

Unfortunately, this lack of stability not only plagued girls growing up, but it also continued during and after their pregnancies and in many cases became worse. Participant G became pregnant at 15 years old. Over the next two and a half years she lived in ten different places sometimes on her own and sometimes with family or friends. The story of participant E portrays the instability that some of these young mothers have to deal with on a continual basis. This was the same young woman who reported that she had a low birth weight baby because of inadequate nutrition. After she had her baby, she had to continue living with her mother.

> **Then after I got over that [postpartum blues] and got over the problems at the place where we were living because at the present time we were living with my friend Heather[6] and her family. And well we had some problems there because my mom wasn't paying Heather's mom any rent so we had to leave there. And you know having a newborn baby and all.**

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[6] Pseudonym

We got an apartment not to far away from Heather's place. Actually it was half a block away from Heather's place with my mom and my sister. That wasn't very good either. She [mother] didn't even have Social Services to support her. Like she had no income at all. All the food we got came from the food bank. Any money that we got for cigarettes or whatever came from whatever guy she was presently sleeping with.

Before I even moved into the foster family I lived at my boyfriend's brother's place for a while with him and his wife. And they were just newly married so my being there was kind of causing problems you know. They didn't have that, I guess you could say, bonding time or whatever that a new couple needs. So I got kicked out of there. I went and lived with Heather for a while. Things didn't work out there. Well I didn't get kicked out of there, I moved out of there because I didn't want to put up with the shit there any more. And then moved in with the foster family.

[Wow. You haven't been in a place for more than a few months.] **I was used to it though because like with you know my mother not having any income or anything, we were constantly being evicted, having to move place to place. That's why we moved in with Heather and her family because we got evicted and the hotel wouldn't let us stay there any longer. (E)**

At one point, this teen's living situation was so tenuous she had to let her baby live with the baby's father and his family. Another young woman got in with a bad crowd after having a miscarriage; she attributes part of her poor coping with her lack of a stable home.

You know, what was I thinking? I had never hung out with a crowd like that, like why didn't I deal with it more rationally? Well, it was probably because of where I lived and the stability of the home I was living in. That was just really, really tough. (B)

Many of these young women were independent at a very young age. Some were physically independent because they left home; others were still living with parent(s), but they were not receiving a lot of parental care or guidance. As mentioned earlier, three of the participants left home at age 13 or 14. Although they sometimes stayed with family or relatives they were essentially on their own. One of these girls had a mother with a mental illness, and she and her brother had to make it on their own even when she lived at

home. **"We took care of her, we took care of ourselves, and took care of the house" (A).** Participant G was allowed to live with her boyfriend in a house that her parents owned when she was 15 years old. Sometimes a girl's parent(s) would move and she would decide not to go with them. Participant B was two months shy of her seventeenth birthday when she decided to move out on her own rather than move to another province with her father.

> **My dad decided to move to [an Alberta city] and I chose to stay in [a Manitoba city]. I had a boyfriend at the time. I had good friends. I didn't want to move. I wasn't ready. (B)**

This same girl got involved with drugs while on her own and trying to deal with a miscarriage. Fortunately, she was able to return home.

> **I ended up doing things I never thought I would do. Never fathomed in my lifetime. And that's when I got into the, I tried the cocaine, I tried the drugs. And ah I went through it for a week. A whole week I was real depressed. I was just, I didn't want to die, I was just really sad. I just snapped out of it one day and said I got to go home. And I just went home. It just took that week. And I went home and my dad packed up my stuff and took me to [city] and said that was it. (B)**

Living with parents did not guarantee supervision or positive role modeling. Some parents allowed their children to skip school, have boyfriends stay over, or stay out as much as they wanted. In the story of participant E above, it is apparent that the mother was not providing basic needs let alone supervision and positive role modeling. Even growing up in an intact two-parent family did not shelter teens from the party life.

> **Partying. Boyfriends left, right, and center. Like it was pretty much the rebellious youth stage. You know hum I had a lot of dabbling with...I think every kid drinks I mean you know but drugs. Nothing serious I did, you know, your marijuana and stuff like that. But one day, one day I just woke up and realized (and this was before I was pregnant) I don't like this life. I hate it. I tried committing suicide once. It was just, and then the next day I realize what the hell am I doing. You know like you have so much going for that you don't even realize. And it was things like that that brought me out of it. And then getting pregnant...(C)**

The pressures of adolescence and trying to make it on one's own are too much for many young women. Participant M dropped out of school in Grade 11 for three months and gave the following explanation: **"[I was] suicidal, couldn't handle the pressure of school and of living on my own and dealing with all the problems by myself".**

In addition to all the problems already mentioned (divorce, instability, family problems, and lack of guidance) a number of the participants also had to cope with abuse[7]. Five girls indicated that they had experienced verbal abuse.

> **And then after 4 months, we started having—well me and my mom started arguing even more. And my boyfriend was there a lot of the times when we were arguing. And he kind of, you know, pointed out to me what was going on. Pointed out that I was being verbally abused because she was, pardon my language, she was constantly calling me a fuck up, telling me I was a bad mother, telling me if I had any brains at all I wouldn't have gotten pregnant at 15 blah blah blah. So my boyfriend pulled me out of that situation. (E)**

Participant A said that physical abuse by her boyfriend was the cause of her two miscarriages.

> **When I was 14 I got pregnant with a boyfriend's baby and he was abusive so I lost—I had a miscarriage to his hand. And I got pregnant again, with his kid again, and when I told him, he flung me into a corner of a table, kitchen table, and I lost it. (A)**

Four participants reported being sexually abused during their childhood. One participant was sexually abused over a three-month period when she was 15 years old, but she never told anyone. During this study, the daughters of the man who abused her charged him, and the participant was asked to testify. The stepfather of one girl offered her $100 to sleep with him. When her

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[7] The issue of abuse was not raised during initial interviews but some stories of abuse came out during informal conversations. Since a number of girls had revealed past abuse, I decided to include a question on abuse on the focus group data sheet. Since not all participants were specifically asked about abuse, the incidence of abuse among participants may actually be higher.

mother found this out, she left him. One participant put a big X on the abuse question on the data form. I later asked her if she was crossing off the question or indicating that she had experience all three forms of abuse. She said that she had a horrible childhood and was uncertain whether she had been abused. She also made a comment about wanting to know what had happened to her during her childhood yet not wanting to know.

Circumstances Surrounding the Pregnancies

A girl's home life and past experiences influence her initiation of sexual activity and affect how she copes with a pregnancy. The circumstances surrounding the pregnancy also influence a young woman's decisions and choices. Participants' explanations regarding contraceptive use or non-use and their comments about their relationships with the father of their child are presented below. This information is useful in understanding the girls' situations, and it is a vital part of understanding teenage sexuality and pregnancy.

Information regarding the participants' age at first sex and first pregnancy along with the age of the fathers is presented in Table 1. The average age at which participants became sexually active was 13.7. One girl reported having sex for the first time at age 11. Most girls were sexually active for one to two years before getting pregnant; however, one girl got pregnant six weeks after becoming sexually active. The average age of first pregnancy was 15.6 ranging from 14 to 18 years old. The average age of the father for these pregnancies was 18.3. The fathers were anywhere from one year younger to nine years older than the participant.

Table 1 Sex, pregnancy and age

	Average	Range
Age at first sex	13.7	11 - 16
Age at first pregnancy	15.6	14 - 18
Age of father (for 1st pregnancy)	18.3	14 - 25
Father's years seniority (all pregnancies)	3.6	-1 to +9

The 13 participants had a total of 21 pregnancies. Some participants indicated they had been on the pill, some had been using condoms, while others had not used any contraception at all. The details regarding contraceptive use prior to pregnancy are outlined in Table 2.

Table 2 Contraceptive use

Contraceptive used prior to pregnancy	Comments	Number of pregnancies	Total pregnancies
Oral contraceptive	took properly	4	
	took irregularly	3	
	took antibiotics	2	9
Condoms	used inconsistently	2	
	always used	1	3
None	used nothing	6	
	planned pregnancy	3	9
			21

Four of the girls (A, B, D, M) who got pregnant while on the pill claimed they took the pill properly and still got pregnant. Upon further questioning of participants using oral contraceptives, three participants admitted that they did not take the pill at a regular time each day. Participant C and participant I were not aware that they were supposed to take the pill at the same time each day.

> **I've been on birth control since I was 12 to regulate my period. I'd never missed one pill. That time I took a pill, I didn't know that you were supposed to take them at the same time every day or that it**

> **really mattered. I thought that it was just like to help you regulate. So, I think I took my pill 5 hours late. And I got pregnant. (C)**

Participant K knew how to take the pill correctly, but she took the pill whenever she got up, which varied considerably. Participants A and H had taken antibiotics while on the pill.

> **No, I think it was the type of pill that I was on and I was on antibiotics the first time.** [And did you know that antibiotics could...] **My doctor didn't say anything about it. It was the first time I was ever on the pill and my doctor didn't say anything to me about it so I didn't know. (A)**
>
> **I was on the pill and took antibiotics. I didn't know it affected it. (H)**

Participants E and G used condoms but not consistently.

> **[My boyfriend] and I were both under the influence when I got pregnant. 'Cause that was when you know I was being all stupid and stuff. Actually the night that [daughter] was conceived was at a party over at my place...We decided to go outside you know smoke a joint. So I was pretty fried. [My boyfriend] came back to my place...he was just piss drunk. So we were both kind of really stupid that night. (E)**

The night they were drunk was not the first night that they had not used a condom.

> **There was like the occasion where, you know, you just kind of get into the moment, and you just don't care...it was just that at that point in time I didn't care. I didn't think I could get pregnant. Well, I knew I could get pregnant, but you know I was one of those people that thought, "Oh, no, it's not gonna happen to me." And then, it does. You know, yeah, it does. (E)**

Participant G had a pregnancy scare in the first few weeks after becoming sexually active, but her pregnancy test came out negative. After this, she got birth control pills; however, she became pregnant before she had a chance to start them. She did not seem to know when her boyfriend did or did not use a condom.

> **During the two weeks** [while waiting for her next period so she could start the birth control pills] **we didn't use anything I think once. And**

> **other times I realized that he wasn't using it. He wasn't using a condom. Usually he would go into the bathroom, put it on, and come back out. One time he had fallen asleep [after sex] and I thought, "This is kind of strange. He's sleeping with a used condom on." And I looked down and he didn't have anything on. So I don't know exactly how I got pregnant that time. Like, I don't know if it was when we didn't use anything, or if it was when he didn't put anything on. So I don't know. (G)**

She got pregnant again by a different boyfriend when her first child was about nine months old, but this time she said she had been very careful.

> **We were so careful. And plus, we barely ever had sex. That's what makes this another big thing, we barely ever had sex to actually make a baby, you know...We used a condom every single time...And I mean, I know he used it, because I saw it in the garbage the next morning, so, I mean, I know that he used one. I know that he would never try and, you know, poke a hole in it or—I know I wouldn't do that, you know. So it was just, for some reason it didn't work. So who knows? (G)**

Some participants explained why they did not use any contraception. Participant A got pregnant when she was 14 years old, she was a runaway and the police were looking for her so she was to scared to access services. "**I was a runaway; I wasn't about to go to a doctor!**" Later, she was told that she could not conceive so she stopped using contraception.

> **I had a fallopian tube infection. I was in the hospital for it for two weeks, and they told me I couldn't have children. They told me to go off the pill, so I did and I was pregnant with my daughter a month later. (A)**

Access to contraceptives was an issue for another participant; she had sex anyway believing "it won't happen to me".

> **I didn't have health care because I had only lived in Ontario for like 2 months so I couldn't get on the pill or anything. And I was allergic to the other source, well another source.** [So why did you go and have sex then?] **Because I was stupid and didn't think it could happen. I honestly did not think I would get pregnant. I was so stupid and naive. Yes, I was allergic but I should have really tried other methods. (J)**

Participant B resumed sexual activity shortly after her baby was born. She had both knowledge of and access to contraception, but she chose not to use any.

> **I guess—I don't know. I'm not scared of being pregnant again. Like, I know it's too soon for my body to be pregnant. Like, God! My body would go through hell. But I'm not scared about it. I'm really not. If I get pregnant, I get pregnant. I'm really pro-creation. I really believe in pro-creating, and I don't believe in a lot of contraception. I just don't. I think, like the pill changes your biochemistry in your body. It makes your body think it's pregnant when it's not, and I think that's really bad...Like I said, maybe I'm just being stupid, but I'm just not scared. I'm not scared to be pregnant again. I miss it. I enjoyed being pregnant. I enjoyed getting big and lots of attention. It was nice. (B)**

The result of her unprotected sex was another pregnancy less than two months postpartum. When the reality of another pregnancy hit, her attitude changed. She decided to have an abortion because she would not be able to handle another pregnancy and another baby; she felt it would not be fair to her newborn son. Plus, by that time she did not want to have any connection to the baby's father.

Three of the pregnancies were planned. Participant A planned a second pregnancy after she had her first child and married. Participant B planned a pregnancy when she was 18 years old, but she miscarried a few weeks into the pregnancy. She planned another pregnancy when she was 20 years old.

> **I was dating this guy...He wanted a baby and I wanted a baby. And so we got together and decided that everything was going to be okay. We were going to get married and have a baby. I liked him. (B)**

They broke up when her boyfriend revealed that he was gay; a couple of weeks later she found out she was pregnant. In a later interview participant B disclosed that she actually was not sure who the father of this child was as she had slept with another man the same week.

The father of the baby and the relationship the young woman has with the father affects the decision made regarding the pregnancy and will definitely affect the woman who chooses to keep the baby. The nature of the relationship between the young women in this study and the men who impregnated them is explored next.

Two participants had not been seeing their boyfriends very long before they got pregnant.

> **He was my first. I'd only been dating him for about 5 to 6 weeks before I got pregnant. (G)**

> **I was with [my boyfriend] for maybe four months; then I got pregnant. (F)**

Participant C admitted that the relationship was just a "fling", but she did not feel she could go through with an abortion or adoption so she chose to keep her baby.

> **He was 25 years old and I was 17. I didn't know this. We met at a pool hall one-day. And I'd seen him 5 or 6 times and we started talking and we became friends then we started dating. I was 17, he thought I was like 19 and I thought he was like 20 okay. Like we had very poor communication. And we started seeing each other and when I found out I was pregnant I told him and I was crying. He's like "What is your problem? Go get an abortion." Yeah okay well I'll get right on that you know** [sarcastic]. **And then I thought about it long and hard and I looked at all the kids now and how they're "Oh my boyfriend left me 'cause I'm pregnant". And I think about it; what are the chances that we would have stayed together. And I think it is better off this way. I'd rather that [my daughter] have one parent who has unconditional love than two parents who are going to fight, who aren't going to love each other. 'Cause I mean I didn't love him. It was a stupid fling. It happened. It was a mistake. (C)**

One participant did not find out she was pregnant until she was six months along; by this time she was no longer going out with the baby's father.

> [How did your baby's father react telling him you were 6 months pregnant?] **Well okay he ah, we weren't together. We had broken up in November and I had found out in February. And he automatically just wanted to get back together with me. So everything was going**

> **okay and we decided to keep the baby and everything like that. But within a month he broke up with me again. Then a month later he came crawling back. Then later, a month before my due date he leaves and took off, out of the province and everything. He wasn't there through the birth, nothing. And he wasn't there for the first 3 months.** [And he is now?] **He has custody of her right now** [since the child was about a one-year-old]. **(H)**

Many of the girls reported this type of on and off relationship with the baby's father.

> **He was working on the inside on his car and he threw a wrench at his engine when I told him I was pregnant because it wasn't his first. So, he was quite mad. He wanted it kind of. Then he broke up with me. Then he came back and wanted to be with me and have a whole family with me. Now it's just over. (J)**

One boyfriend wanted his girlfriend to get pregnant, but when she did he did not stay.

> **At first he was talking to me about wanting one** [a baby]. **And I said, "No, I'm too young. It's too early." You know, whatever. And when I told him I was he said well I'll help you out and everything like that. And so he wasn't doing anything, so I talked to him about it. And just nothing. And I don't know, we just broke up...It's a long story. (I)**

Relationships that appeared to be okay usually withered away after the participant got pregnant, and she was left to deal with the pregnancy alone.

> **With [my first boyfriend] it wasn't as serious because we were only going out for like, you know, six weeks before. But, um, with [my second boyfriend], we were dating for like ten months, and, you know, we were doing okay, but the pregnancy just put way too much pressure on the relationship, and it collapsed. But it's not—it would have collapsed anyways, with me being pregnant or not. It might have taken a little bit longer, but we weren't happy. (G)**

Unfortunately, participant G's first relationship did not end so nicely. She broke up with her first boyfriend three weeks before the birth of their baby. He threatened to sue for custody; he wanted his parents to raise the child. Then he harassed her for five months, even threatened her life.

> **And he's come to my house with, well my balcony you know, harassing me. Once me and [2nd boyfriend] started dating, he was**

harassing both of us and saying that he's going to stand on top of my apartment building and shoot everybody that comes out. (G)

Even participant A who married the baby's father had an unstable relationship that eventually fell apart. They got married because she was pregnant: **"We wanted her [daughter] to have a family name. Our family."** Over their three-year marriage, they separated and reunited three or four times. At the time of the follow-up interview, they were planning to file for a divorce.

School History

Pregnancy during a girl's adolescence will invariably impact her schooling; however, other factors such as family background and personal attributes also affect one's school experience. Eleven of the thirteen participants were attending school at the time of the first interview, but all participants had dropped out of school at some point. Frequent moving in their families of origin resulted in many school changes for some participants. **"I went to 13 different schools in 12 years of school" (B).** Two participants cited frequent moving as their reason for dropping out of school. Participant I explained that she moved four times during Grade 8. She would go to school for a few days then drop out; she was tired of starting new schools and having to make new friends. At one point, she was charged with truancy, but she still did not attend school very often. Sometimes participants changed schools within their city. All of the focus group participants had moved from regular Public or Catholic schools to an outreach school.[8] The five interview participants who were in school were also attending outreach schools.

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[8] Outreach schools target students who are not "making it" in the regular school system or those students who have already dropped out. They usually are located in malls and have a less structured environment. Students follow a flexible, self-paced modular curriculum.

Participants' level of achievement in school prior to dropping out varied from poor to excellent. Six participants reported average or below average grades. Participants B and G reported doing very well in school; participant G was even in an advanced class.

> **I didn't find I was falling behind because I was always really smart like I always got A's. As long as I did the work I did really good...Yeah, I always did excellent. But it was only really in courses that I liked. (B)**

Only one participant indicated that she had difficulty in school.

> **I'm not very good in all of those [subjects]. So, I guess that's another reason why I dropped out is because I figure I can't do this, Why should I be here? (A)**

Some girls did not attend school frequently enough to complete courses and receive grades.

Five of the participants had a history of dropping out stemming from junior high. Participants J and I cited family upheaval and moving as the reason for their sporadic school attendance, and participant A dropped out of school after Grade 8 because of family problems and never returned.

> **I had an authority problem, a very big authority problem. I was having a lot of problems at home with my mom, dealing with my mom and her illness. And I couldn't concentrate on school. I just wanted to get out of the situation that I was in so I ran away. And once I got a taste of freedom and no school and that kind of stuff. When I did move back with my mom to help her out a bit, I tried going back to school but I was so used to doing things my way because I was on my own. And I had teachers trying to you know be the boss again and I just couldn't have that. (A)**

Participant D dropped out in Grade 8 because she could not handle the pressure and stress.

> **I just found the work too hard. The teachers were just piling the work on me. I was just getting stressed...I just couldn't handle it. I was doing good, I just couldn't handle the teachers putting so much pressure on me... so I just dropped out. Then I went back to [a**

> **Catholic school] and got my Grade 9. Then I just started coming here [outreach school]. (D)**

Participant F dropped out of school every year, but the school kept advancing her to the next grade anyway.

> **I was in Grade 8, dropped out...I went to a new school. I don't know how it worked. I just went and was in Grade 9. Then I dropped out of Grade 9...Grade 10, dropped out...I was always dropping out or in school. And then I became pregnant. (F)**

For the remaining seven participants attending irregularly and dropping out began in high school. Tenth grade was a particularly bad year for a number of girls. Once they started high school, they also started skipping classes and partying.

> **It was kind of more like I skipped a week here and skipped two weeks there and just didn't go. There was more important things I thought going on in my life. There was boyfriend problems. Or I was out at the bar drinking too late and I just didn't feel like going. Or when I moved out on my own and started working. (B)**

> **My beginning year of Grade 10, I went to [a public high school]. Wrong crowd, wrong everything, you know drinking and partying and you know school—5 credits the whole year. (C)**

> **I would say "Oh mom I got a stomach ache" and boom you could stay home. That worked for a couple days, you know, then you would have to go back to school for a day or something like that. You were sick again the next day, you got to stay home. I took advantage of that. So I skipped so many classes that they eventually kicked me out. So, then I had to do Grade 10 all over again. (E)**

> **I was a teenager, just partying, getting into liquor, getting into drugs, starting to smoke. (F)**

> **I would go to school, but I wouldn't go to classes. I'd go to Dairy Queen or go to the mall but I would go to school, 'cause, I mean, I would go and get all my friends first. So we did—well, we'd do that, and then I just eventually, probably by the end of December, like just before the Christmas break, I wasn't in school any more. (G)**

The temporal sequence of dropping out and pregnancy varied among participants; four different scenarios and end results are outlined in Table 3.

Table 3 Pregnancy and school dropout

Scenario	Participant (pregnancy #)	End result
(1) Dropped out then got pregnant	A12345	Never returned
	B34	Returned at 6 months postpartum
	F	Returned after birth
	H	Returned during 2nd trimester
	J	Returned after birth
	L	Returned during 1st trimester
(2) Got pregnant then dropped out	B1	Returned after 5 months (had abortion)
	C	Out briefly then found outreach school
	K	Returned after 1.5 year drop out
(3) Became pregnant during the process of dropping out	B2	Two year drop out then 3rd pregnancy
	E	Returned after birth
	G1	Returned during 3rd trimester
(4) Became pregnant and stayed in school	D	Continued at outreach school
	G2	Continued with home schooling
	I	Changed to special school
	M	Enrolled in outreach school

Six participants got pregnant while they were out of school (scenario 1). Five of them eventually returned to school: two during their pregnancies, two after the birth of their children, and one at six months postpartum.[9] Participant A dropped out of school after Grade 8 had five pregnancies (only two live births) and never returned to school.

Ten pregnancies occurred while participants were enrolled in school, but their situations varied. Three participants dropped out after becoming pregnant (scenario 2). Participant B changed from her regular high school to a special school for pregnant and parenting teens, but she was only there briefly before she dropped out and had an abortion. She missed five months of school before returning. Participant C went to a public high school for her Grade 10 year, but she spent her time partying. She switched to a Catholic high school

[9] Participant B's third pregnancy ended in parenting and her fourth in an abortion. She had been out of school for two years and was looking into returning to school when she discovered she was pregnant for a fourth time. Her plans to return to school influenced her decision to have an abortion.

for the next year and was doing well, and then she got pregnant. The teachers and principal were not very accommodating so she dropped out.

> **Then I switched over to [Catholic high school]. I did good there. I don't approve of their school. I don't like the way it is run. It is almost like they are trying to make it a school for the elite and rich. They really did a lot of hum...spring cleaning I guess you could say, with the kids, trying to ship all the kids that were—that had** [undesirable]. **Yes, into a public school. The principal there is very stuck up, very society. He wants people to look at his school and think it's the best school in the world. So when I got pregnant, I felt really out of place there. (C)**

Fortunately, this participant started attending an outreach school she had heard about from a friend. Another girl had a similar experience at the same school, but she dropped out of school completely instead of finding a new school.

> **I tried going back to [high school] but I had problems there. I was skipping and since my due date was in June, he [the principal] suggested, well suggested rather unkindly, that perhaps I should wait until after I had my child. So I did. I waited a year and a half.**

Although some participants were already in the process of dropping out of school when they found out they were pregnant (scenario 3), the pregnancy added to their school problems and was very influential in their decision to officially drop out of school.

> **I found out I was pregnant I think December first, and I had been slowly dropping out. So I didn't really go to school very much when I was pregnant, only maybe for the first three weeks that I found out afterwards...**[But you said you were goofing off even before you found out you were pregnant.] **Well, yeah, but I mean, it wasn't as bad before I found out I was pregnant. I was going to school. I had to go to at least, you know, seventy-five percent of my classes a day. I might have skipped one after lunch or something, or I wouldn't go to phys. ed. or you know. I'd go to my main classes, though...It wasn't working. The teachers weren't nice at all. I didn't like the teachers there. They were, you know—I had one teacher who helped me out, 'cause I guess he knew I was pregnant or something, but I mean, I just felt really different. (G)**

Participant B was living on her own, working and trying to go to school. She decided to leave school just before she found out she was pregnant.

> **When I was 17 years old, I worked full time. Couldn't go to school full time and work full time, couldn't do it—too much. And nobody understood, none of the teachers understood, none of them...I couldn't do it. I just decided this is way too hard, you can't do, you can't do Grade 12 math and waitress at night. There's no way. (B)**

Participant E was expelled for a second time because of too many absences. When she found out she was pregnant, she decided not to bother trying to get back into school.

> **I didn't want to have to, you know, walk down the hall. Well pardon me, I didn't want to have to waddle down the hall. And, you know, have people talking behind my back and calling me a slut because of my age, being pregnant at that age and everything. (E)**

Four participants managed to stay in school both during their pregnancy and afterwards (scenario 4). Participant I found out she was pregnant at the end of her second year in Grade 9. She completed the year and then started at a school for pregnant and parenting teens the following year. Participant M finished Grade 12, got pregnant over the summer, but she enrolled in an outreach school for upgrading in the fall. Two participants who were already attending outreach schools when they got pregnant found they were able to continue with school without too much difficulty.

> **I just was there through my whole pregnancy. It was really easy. I didn't have people hassling me about being pregnant and telling me what to do. Like we can do our work there, try to do it there at our own pace. So no one is forcing us to leave or anything. Not forcing us to leave just not making us mad so that we would have to leave. I liked it. (D)**

Participant G had been doing her schoolwork at home since her first pregnancy and when she got pregnant a second time she just continued with her home schooling. The birth of her second child did not interrupt her schoolwork.

Participant C who had started at an outreach school during her pregnancy also found that the flexibility of the outreach school allowed her to keep up with her work during the latter part of her pregnancy and early postpartum period.

> **My ninth month, I took it off, and that was no problem. I still did my work. My girlfriend brought my work in for me. After I gave birth, I took a month and a half off from school. That was no problem. (C)**

Pregnancy affected the schooling of all the participants in some way; however, the degree of influence of other factors in girls' decisions regarding school is difficult to determine.

Complexity and Change

One word could be used to describe the participants' past experiences and present situations—complex. The lives of some of the interview participants were so complex that a timeline had to be made of their living situation, school history, and pregnancy information in order to fully comprehend the sequence of events taking place in their lives. Sometimes it took a number of questions to get the complete story as the lives of these girls are neither simple nor straightforward. It took me the whole interview to get the situation of participant D straightened out. She said that the baby's father was involved with the child and that she lived with his mother, I assumed that she was still dating the baby's father. Later in the interview, I found out that the baby's father was involved initially but that he was presently in jail. Then when I asked her about the relationship she said **"Well, we're not together. We're just talking."** Do not assume anything!

Knowing there would be less opportunity to elicit contextual information from the focus group participants, a number of questions were added to the data form. Care was taken to design questions that would capture the

complexity of the participants' lives; however, I still had to meet briefly with some of the focus group participants to clarify information. For example, when answering question 11 about past living situations (see Appendix I), one participant indicated that she lived on her own at 14 years old. I wanted to clarify how this was possible. She explained that she dropped out of school and worked full-time. Questionnaires really over-simplify the reality of these girls' lives. Their lives do not fit into forced choice answers and their situations cannot be explained in a few short words; this validated the need for qualitative research that included in-depth conversational interviews as one method of data collection.

The complexity of participants' lives was in part due to change. There was ongoing change in the family unit, living situation, school status, and romantic relationships of these girls. Many of the participants lived in a variety of family units growing up including two-parent, single parent, stepfamily, and other variations. Their family units and living situations changed frequently. Many of the girls moved a number of times, which also meant changing schools. School changes were not only due to moving. A number of the girls transferred between school systems and schools, sometimes as a matter of preference other times because they no longer met the requirements of the school they were attending.

> **My schooling was doing pretty good but second semester was when they informed me that I couldn't come back because I had used up my three years. So I had to go to either Centre High or find an outreach school or something like that to go to. (E)**

Romantic relationships were also subject to a lot of change. I interviewed participant A in September 1997 and did a follow-up interview with her in April 1998. She was married at the initial interview and did not suggest

that there were any marital problems. Over the next eight months I had sporadic contact with her and each time her status had changed. She was separated and reunited with her husband a number of times. At the time of the last interview, she was getting a divorce and was engaged to another man. Participant B reported changes in her romantic relationship weekly. She went on a date one week, the next week the man was living with her, a couple weeks later she could not stand him and had him moved out, then he was the sweetest man she had ever met. In the end, the relationship only lasted about two months. The amount of change or instability that these girls experienced not only during their childhood but also in their present situation made follow-up important. I had ongoing contact with four of the interview participants over a period of eight months and was able to witness changing circumstances in their lives. Follow-up interviews were also conducted with six of seven interview participants. Participant F could not be found; she had stopped attending the school she was at and had moved. This in itself speaks of the change in her life.

The themes of complexity and change did not really fit the lives of two participants. Participant C, who had a one-year-old daughter, and participant L, who was pregnant, grew up in intact, two parent families and were still living with their families. They were from middle class families and had stable living situations. They talked about having good relationships with their parents and extended families. Their families were very supportive of them. One girl talked about how her life was different than other teenage mothers.

> **I have it pretty easy compared to a lot of people who are pregnant at my age...We all shared the responsibility [of raising daughter] in a sense because it is very hard...Like if I were to be going to school and being on my own like some of the girls in the school, I don't**

think I could do it. I am very dependent on my parents not for like materials things but for emotional things. (C)

The families of these two participants provided stability. Although their stories did not fit the overall themes of complexity and change, they did have a number of factors in common with the other participants. For instance, they both became sexually active at 14 years old and experienced a period of school drop out. Their description of experiences, perceptions, and needs, which will be explored in the next chapter, were also very similar to the rest of the participants.

It is important that we understand the context of the girls' lives so that we can better understand were they are coming from. Participants' past experiences can give us insight into their current behavior. The girls' family situations tell us a great deal about their support systems and ability to cope with challenging circumstances. Knowing the context also allows comparison of experiences and needs of participants from different backgrounds. The background presented in this chapter should be used as a frame of reference for understanding and interpreting the findings about participants' experiences presented next.

Chapter V

FINDINGS

The scope of this study was purposely very broad as a narrow focus could "unknowingly exclude what is relevant" to the population under study (Muecke, 1994, p.203). The research questions provided some guidance in data collection; however, participants were free to tell their stories and talk about what was important to them. Participants' stories included information about their past, present, and future. What they shared about their experiences during pregnancy and parenthood was valuable information that health, education, and social service professionals could use to inform their practice and improve service delivery.

Chapter IV provided some contextual information about the participants' lives, which serves as a frame of reference for the rest of the findings. This chapter begins with a walk through the collective experiences of these young women starting from the moment they suspected they were pregnant, through their pregnancy, into their first years of parenthood and ending with their dreams and aspirations. This chronological journey through their lives will include information on their issues, concerns, strengths and needs plus their experiences with services and school during this time. In the second part of the chapter several themes that emerged from the interviews and observations are examined.

Pregnancy

Finding Out

Most of the participants suspected or knew they were pregnant even before having a pregnancy test: **"I knew right away. My periods were**

usually regular" (K). Only two girls were not expecting to be pregnant. Participant I accompanied a friend who was having a pregnancy test to a clinic, and she decided to have a pregnancy test also. It turned out that she was pregnant and her friend was not. All the participants had their pregnancies confirmed by a doctor including three participants who initially did a home pregnancy test. The girls usually went to the nearest medi-centre for a pregnancy test; three participants went to their family doctors. Participant C received a negative pregnancy result from her family doctor. She went to a medi-centre the next day because she still believed she was pregnant, and this time the test was positive. Participant H's mother made her do a home pregnancy test and when it was positive she went to see a doctor who informed her that she was six months pregnant. She claimed she did not know she was pregnant. She explained that she was under a lot of stress and had not stopped menstruating. Two participants mentioned going to two different pregnancy counselling centres but not until after they found out they were pregnant.

The participants experienced a mix of emotions when they found out they were pregnant. Their emotional state seemed to progress through four stages. Even though most of the girls suspected they might be pregnant, being told that they were indeed pregnant was at first shocking. For those girls who were not expecting to be pregnant, there was a feeling of disbelief. After the shock or disbelief, many of the girls were scared and did not know what to do, but soon they were excited and happy about the pregnancy. Finally, the participants seemed to end up feeling "scared but excited".

I was just so scared. I mean I was happy, I figured that you know it probably would happen one day but I wasn't expecting it to happen when I was 15 years old. (G)

Mostly happy after the initial shock wore off, still scared though. (A)

Even a repeat pregnancy brought excitement and happiness not dread or dismay. Participant G got pregnant at 15 years old, and she found out she was pregnant again when her baby was 9 months old. Her initial reaction was disbelief, then she was excited. She did not mention being scared the second time. **"I was excited. I mean I was smiling and I was happy but I was like, How can this be happening? This has already happened to me."**

Sharing the News

Three of the girls had discussed their suspicions with their boyfriends before going for a pregnancy test. Two of these boyfriends accompanied the participant to the clinic. The rest of the girls told their boyfriends after they had confirmed the pregnancy; he was usually the first person they told. The reactions of the participants' boyfriends varied from one extreme to the other. One boyfriend was physically abusive after he found out his girlfriend (A) was pregnant and his abuse caused a miscarriage (this happened twice). Some of the other men initially felt some anger, but this quickly passed. Others were just shocked; sometimes they thought their girlfriends were joking or lying. Participant D's boyfriend reacted by saying that it (the baby) was not his, later he became more accepting and supportive. Participant C was upset and crying when she told the man she was dating and he coldly responded **"What's your problem. Go get an abortion."** Participant F said her boyfriend was scared and left her. A few of the boyfriends were happy at the news while a number of them had mixed reactions and were in and out of the girls' lives a number of

times over the course of their pregnancies. Sometimes the men did not really react at all.

> **He didn't really react to it (the pregnancy) right away. And then about a week later, we were lying in bed and he put his hand on my stomach and he goes "Wow". We didn't really talk about the pregnancy. (G)**

The participants usually told their parents within the first days of finding out, although they sometimes would talk to their friends or siblings first. Participant C waited six weeks before telling her parents. She was one of the girls from an intact family and was worried about letting her parents down. Some of the parents were initially upset. A few of the girls' fathers (E, H, J, M) had very negative reactions. After some time, these parents were "okay" with the pregnancy and supportive of their daughters. Participants E and F said their mothers were happy and participant K said her dad was "very, very happy".

The participants' friends were generally very supportive. Participant F commented that most of her friends had kids. Only two girls talked about unsupportive friends. Participant B's supposed friends gossiped about her, and she did not talk to them anymore. Participant G said **"They weren't really my friends, they were my boyfriend's friends."** The girls talked about how older people stared at them, whispered behind their back, and were judgmental and sometimes even shocked and disgusted: **"Older grandparent-type people usually look down on me".**

<u>Options</u>

Some people's reactions were to suggest the participant abort the baby or place the baby for adoption. These options were rejected by all but one participant. The general consensus among participants regarding adoption was **"I don't think I could carry a child for 9 months then give it away".**

When asked what made her a good mom, one girl responded **"The fact that I kept my son at such a young age and didn't have him then give him up".** The girls do not have anything against adoption, they just do not think it is something they could do. Apparently, some girls believed the more responsible decision was to keep the baby.

Abortion was also ruled out by most of the participants: **"I am incredibly against abortion", "I could never go through with that", and "I didn't want to just throw a life away".** Participant B who had an abortion when she was 15 years old felt pressured into it, and she had some difficulty dealing with it afterwards. This is the same young woman who later made the statement about not being scared to get pregnant again and being "pro-creation" (quote on page 90), then chose to have an abortion when she got pregnant two months postpartum. Girls' views on adoption and abortion sometimes changed once they were faced with an unplanned or repeat pregnancy.

The participants were not swayed or impressed by people who suggested they choose abortion or adoption. As mentioned earlier, participant C's boyfriend said flat out "get an abortion". Participant M's father wanted her to abort while participant J's father suggested adoption. Participant E was constantly being pressured to choose adoption by her boyfriend's parents. Even health care and social service professionals sometimes pushed other options.

> **My doctor said there is a very strong possibility you are [pregnant] and he said you can come back in next week after we find out the results and we'll talk about abortion. And the first thing I said was there was no way. (J)**

The participants ordinarily discussed options with the baby's father, and he usually said to keep the baby: **"We're going to have the baby. I can't imagine doing anything else. It doesn't seem right to keep one baby and kill the other."**[10] The boyfriends gave their input about the decision, yet half of the time they did not remain nor take responsibility for that decision. It is not known how influential the boyfriends' input was upon participants, perhaps some of the girls may have made a different choice if they knew their boyfriend was going to desert them.

Support

Women need various types of support during pregnancy. Stewart (1995) defines social support as "interactions with family members, friends, peers, and health care providers that communicate information, esteem, aid, and emotional help. These communications may improve coping, moderate the impact of stressors, and promote health and self-care" (p.93). Social support has four dimensions (informational, esteem/affirmational, aid/practical, and emotional), and it can be appraised as negative or positive. Sometimes intended support may be perceived as unhelpful.

The amount of support that the participants had during their pregnancy varied and often changed over time. Those participants who were living at home when they found out they were pregnant tended to stay at home at least until after the baby was born. Some parents were angry and unsupportive at first; however, they usually became more supportive as time went on. One mother who had responded with happiness at the news of her daughter's

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[10] This participant was already parenting one child from a previous boyfriend when she found out she was pregnant by her new boyfriend.

pregnancy did not provide for her 15-year-old daughter's basic needs such as food (E). Participants A, F, G, and M were on their own prior to their first pregnancies and continued to live independently from their parents. Participant B (3rd pregnancy) and G were helped out financially by their parent(s). Participant F who was pregnant at 16 years old had virtually no support and ended up in a youth emergency shelter. She was placed with a foster family about half way through her pregnancy.

As discussed in the previous chapter, some participants were abandoned by their boyfriends while others had on and off relationships during their pregnancies. Therefore, it is likely that the boyfriends were more a source of stress than a support. A few of the boyfriends did stay, but it is not known if their support was perceived as positive or negative by their pregnant girlfriends. Participant M had practical support from her boyfriend and his family as they allowed her to live with them when she had no other place to go.

Informational support tended to come from older women such as their mothers, sisters, aunts, boyfriend's mother or foster mother.[11] Most girls sought out or were given information in the form of books and videos. A few of the participants also had friends who were pregnant or had recently had a baby and although they were sometimes used for informational support, their role seemed to be to provide emotional and affirmational support.

> **I also did have that one girl who was pregnant with me. Like when my body started changing I'd call her at two in the morning. "This is happening, is it supposed to?" You know she was 2 to 3 months ahead of me so she'd say yes, yes, yes. You know she was basically my support. (C)**

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[11] The informational support that participants received from health care professionals will be discussed in the next section.

Sometimes girls lost their friends after becoming pregnant. For example, one girl lost a number of friends the previous year because of a fight; and then once she got pregnant, she lost more.

> **Some people don't know how to act around you. Other people think you're no fun any more. You can't drink. I couldn't do any of that stuff. I was tired all the time and I was throwing up. I was working and you know there was just lots of things, and I just wasn't any fun any more. (G)**

For many of the participants support was volatile. The amount of support they received during their pregnancy seemed to be dependent on the type and quality of relationships they had with their parents, their boyfriends, and their friends.

Services

Other potential sources of information and support were health and social services professionals and community programs. Participants' experiences and comments in four areas will be examined: (1) prenatal doctor visits, (2) Health for two prenatal program, (3) prenatal classes, and (4) labour and delivery.

Prenatal doctor visits

About half of the participants said that their doctors were great. Girls were happy with their doctors when they were non-judgmental, took time to talk with them, explained things, asked how they were doing, and developed a rapport with them.

> **He's a really good obstetrician. Like he really takes the time to care for you and to say, "Hey is everything going okay". When I had my false labour I felt so stupid for going in and he gave me a hug. And you know explained to me a lot more. He's very touchable. He tries to make it almost on a personal level still keeping the professionalism. (B)**

Conversely, the girls who were not happy with their doctors may comments such as: **"don't talk to you at all", "don't give you enough information", "too busy, you're not a priority", and "don't answer your questions".** One doctor acted in a way that could be viewed as unprofessional and unethical.

> **I didn't go to the doctor till I was about four months pregnant. And then I went to one doctor, and he had something terrible against single moms. You know, you figure it's your first doctor's appointment ever, I'm already in my second trimester, I'd get weighed, I'd get my blood pressure taken and get my blood taken and everything, and I didn't get any of that. I got—he felt my stomach, said, "You're about fourteen weeks along" and walked out and that's it. And then I'm like, well, this isn't right, you know. (G)**

Luckily, this girl went to another doctor. The second doctor did the "right things", but he was not great; he did not develop a rapport with her nor answer her questions.

Most girls were dissatisfied with the amount of information provided by their doctor. Sometimes their questions were answered vaguely or not answered at all but many times they had not asked any questions: **"That was my first kid. I didn't know. I didn't know what to ask".** Doctors also did not go beyond their medical roles. They did not assess the girls' situations as to whether they had housing or proper nutrition nor did they refer the girls to other relevant services. Only one doctor went beyond her medical duties. She had information in her office about the prenatal support program, spent time with the participant doing prenatal teaching, lent her some videos, and had her fill out cards to receive free samples such as formula. The girls did not know enough to ask about other programs and services, or they did not feel comfortable asking their doctor questions.

Health for two

Eleven participants found out about this prenatal support program, although many did not find out about it until later in their pregnancy. The program is a community-based prenatal nutrition, information, and support program that uses milk coupons and free prenatal vitamins as a hook to get pregnant and breast feeding women to come into agencies. Once they access the program, they are supposed to get prenatal information and practical and social support. The participants found out about the program from a variety of sources including friends, school staff, social service agencies, and sometimes doctors or clinics. Fortunately for the girls in the focus group, there was a family support worker who came to their school and delivered the prenatal support program as part of a teen parent intervention program.

Comments regarding the usefulness of the program varied. All the participants appreciated the milk coupons; however, some parenting girls pointed out that they needed formula more than milk and that milk was needed more when the children were older than when they were breast feeding. One participant told an agency she was breast feeding when she was not, so that she could get the milk coupons. The level of support given by agencies varied greatly. To the focus group participants the prenatal program and teen parent intervention were one and the same. They liked the fact that the family support worker came every week, conducted group sessions, brought food, and allowed them to "sit and gab".

A couple of interview participants received very little support from the agencies they went to.

> **They weren't very helpful. They didn't ask, you know, how am I feeling or how am I doing? They just asked, you know, the questions**

> **that were on the paper, gave me my coupons, and that was it you know. Then they would say, "Any time you want to talk, come back." But, you know, what am I supposed to say as they're walking away. "I'm having a really hard time with this..." as they're leaving. So, you know, I didn't feel that they were very supportive there. (G)**

One girl suggested that they should have groups or something more supportive. Another girl was very critical of the program and agency she visited saying that natives ran the agency and they were more supportive of this ethnic group. Plus, the "Health for two" books did not have any information she did not already know. She suggested that the services be more individualized.

Prenatal classes

Prenatal classes were probably the least used service. Only three participants took prenatal classes and one participant who was still pregnant planned to take classes. The four most common reasons cited for not taking classes were: (1) could not afford them, (2) would feel too uncomfortable, (3) do not like the content, and (4) did not need them.

Participant F found the classes helpful, but she also said, **"I felt really uncomfortable. I was the only one with a best friend who was a girl. Everyone else had a man, and I was the youngest."** Participants G and I attended prenatal classes for teens, one at a hospital and the other at a school for teen mothers. Despite being with their peers, they still did not like the classes. They both complained about the content especially the breathing and focusing part. Participant G said that it was not a serious class and she knew most of the stuff already. She suggested there should be more time to ask questions.

Some of the girls who did not take classes would have done so if their situations had been different. Participants B and E cited cost as the only reason

they did not take classes; they were unaware that classes are offered free of charge or sometimes fees are waived if you cannot afford them. The information given to them and the people they phoned did not mention anything about free classes, and the participants did not ask if there were any. Other girls did not want to take classes with older women and did not know there were classes for teens only.

> **I was going to sign up at (the public health centre). I was there getting my daughter's shots and I was pregnant with my son. And I saw all the moms coming in and not even one of them was under 25. And I was like "NOPE". (A)**

Many of the participants mentioned they did not want to go to a class to learn how to breathe and relax. They already knew how to breathe plus no one really stops and thinks about breathing in the middle of labour. Participant C said, **"It's really weird, a whole bunch of pregos sitting in a room talking about constipation and all those lovely things. And I just thought no, I don't think so."** Many of the other girls thought they had no need for classes. They read books and watched videos at home, and their mothers or other females in their lives told them what to expect. They also believed that the doctors and nurses would be there to help and support them during labour and delivery.

Labour & delivery

Although most of the participants did not take prenatal classes, they still felt adequately prepared for childbirth. Generally, they had a number of support people at the hospital including parents, boyfriend (not necessarily the baby's father), "in-laws", friends, or other relatives. Participant B was not sure how reliable or helpful her support people would be, so she found a doula (labour support coach). The doula was very helpful; her only complaint was that the the doula could have been more assertive with the hospital staff. This

participant recommended the doula to participant G; she, however, did not find the her to be very helpful. Participant F was alone at the hospital for a short time until her foster mother, who was her only support person, arrived. A number of girls mentioned being "really scared" once they arrived at the hospital, and they did not want to be alone.

The girls liked nurses who were friendly, helpful, talked with them, asked how they were doing, and kept checking on them even if they were not the nurse's patients. However, every participant had at least one nurse they did not like because the nurse was rude, impatient, pushy, intimidating, or unhelpful.

> **There was one nurse that I had when I first went in to the delivery room...She was a bitch. She was so mean. She was just totally not sensitive to my feelings or anything like that. You know I was really scared when I was in there and she was just so rude to me. (E)**

A nurse made participant B walk to the delivery room. The girl had a contraction and fell on all fours and the nurse did not help. Participant A was asked a number of times if she wanted to give her baby up for adoption and was even brought adoption papers, even though her husband was with her and she told them she was keeping the baby. Participant B's step-mother had to tell the nurse that the baby was in distress because the nurse was not paying attention to the monitor. Another nurse pushed morphine into a girl's IV before she had a chance to say no: **"I was really upset with that because I really wanted to do it without drugs and they didn't give me a chance" (G).** One girl was upset that the nurses did not allow her to hold her baby right away. **"They didn't think that I would know what to do and how to touch my baby and how to handle my baby or change my baby" (A).**

Another problem was that the nurses would change (shift change) and there would be a number of different nurses coming in asking the same questions, which annoyed some of the girls. Furthermore, the majority of the participants were upset with their doctors because their doctors were not there to deliver their babies or only came in right at the end. **"My doctor never even showed up!"** Some girls were also upset scared when their doctors were not there.

> **When I was getting ready to deliver a doctor came. I had no idea who he was, and I was really scared. And then my doctor showed up right when I was pushing so I felt comfortable. (F)**

Participant D's doctor came and delivered her baby even though she was not on call. The girl was very happy and relieved because she did not want a male doctor.

Many of the participants complained that explanations were not provided. The staff did not explain what they were doing and why, and when there were complications the doctor made light of them. Participant B had a particularly bad labour and delivery experience. The resident doctor had a lot of difficulty inserting the vacuum extractor and he accidentally cut her, then he sewed her up crooked. The girl had an infection for six weeks afterwards, and at five months postpartum had to get re-sown inside.

Two participants were not happy with their care after delivery. One mom felt she was treated badly because she was a teen.

> **...right across from me was also a teenager and they (nurses) treated her like crap. They were rude. They were impatient. Yet, there was one right beside me, she was 30 something and the other was 26 or something like that. They were treated fine. You know, they were nice to them and everything else. When they called because they were in too much pain or something, they were right there. I mean if I called they came over the speaker "What now?" sort of thing. (A)**

Another mother said the nurses and the lactation consultant could not answer her breast feeding questions and did not notice that her son was tongue-tied; consequently, her difficulty with breast feeding led to her to quit.

Difficulties

There was some difficulty with about half of the fifteen pregnancies. Participant E had a kidney infection at five months and also delivered a low birth weight baby (4 lbs. 6 oz); the baby was healthy and she was discharged the next day. Participant A could barely walk the last couple of months of her pregnancy because her pelvis was separating awkwardly. Participant G's baby was premature, born weighting 5 pounds 1 ounce at 36 weeks gestation. She also had difficulty gaining weight during her second pregnancy and had to go to the hospital a number of times with premature labour. Participant G was able to carry her second pregnancy to term and had a healthy baby boy; however, she did not seem to think having a pre-term baby was a big deal and at one point did not want the doctor to stop her premature labour. Participant J mentioned she had a caesarian section but did not explain why. Two babies (A's and B's) were in distress during labour, and there was meconium in utero. One baby had no breathing or pulse when born and had to be resuscitated while the other baby spend a couple days in neonatal intensive care. Participant C stayed in the hospital two nights because there were clumps of placenta when she passed her urine. A week later she hemorrhaged in a restaurant bathroom and had to go to emergency.

When participants were asked if they had any difficulties during their pregnancy, they reported some non-medical problems. Participant B, who was interviewed during her pregnancy, talked about how difficult the everyday tasks

were. She lived by herself and had no vehicle, so tasks such as grocery shopping were hard. Household chores and even showering and getting dressed were tiring. For participant F the most difficult part was being alone. Her boyfriend had left her and she had no support until she was placed with a foster family, so she was depressed. Other difficulties mentioned were telling parents, not knowing what to expect during labour, and having to get into the habit of really taking care of yourself. In general, participants were under a lot of stress. In addition to the usual adolescent problems, they had to deal with pregnancy-related bodily changes, strained relationships with boyfriends and family, worries about labour and their future. In addition, some participants had to worry about where they were going to live, how they were going to pay the bills, and where their next meal would come from.

Enjoyed Pregnancy

Despite these difficulties most of the participants described having good pregnancies. A number of girls talked about how they really enjoyed being pregnant and how they missed it.

> **I enjoyed it. I did. The pregnancy, I had a lot of fun with it...When I was pregnant I got a lot of positive attention. "Oh, you look so good. You're glowing." And actually, I wish I was pregnant, I never had so many complements you know...And I loved it because I was allowed to be fat you know...This hasn't put a fear of having children on me at all. I can't wait to be pregnant again. Don't actually want to have the child, I wish I could just be pregnant you know for the rest of my life. It was so much fun. And labor was so exciting...I just can't wait to get older and have more kids. (C)**

> **Being pregnant is awesome. It was so nice. I guess it's kind of a combination between, you know, the bond you have with that baby growing inside you. And with me it was kind of, you wake up in the morning and you know that's one more day closer to when you actually get to see your child, so you're all happy and everything. Setting aside the whole kidney infection thing, it was quite pleasant. (E)**

Similar comments were made in the young mothers support group. The girls in the group who were pregnant were really enjoying their pregnancy and were happy and excited. As the others watched these girls progress through their pregnancy and have their baby, they often reminisced about their own pregnancy. They talked about wanting to be pregnant again and have another baby.

Parenting

Adjusting to Motherhood

In general, the participants were happy and excited about their pregnancy, and once their baby came they embraced motherhood. **"I love it. It's tiring. It's exhausting. It's exciting. It's wonderful" (K).** Participant G said she liked being the mom and did not mind getting up in the middle of the night. That is not to say that the participants reported being a teenage mother was a piece of cake. Many girls spoke of lack of sleep, lack of time for themselves, and not being able to do everything they did previously.

Three participants (B, E, and G) experienced postpartum depression; they described being very emotional and crying a lot. Participant C said she had many ups and downs but that the support from her family made it easier. Only two participants were living alone after they gave birth, and both of them were interviewed around two months postpartum. Participant B spent the first week with her father and stepmother before going home. She found being alone at home hard, yet she did not want to rely on others for help because she would have to eventually learn how to cope as a single parent.

> **I hit postpartum (depression) when I was home, but that's when I started thinking about my birth and I started getting upset about being totally alone. I had the support system, and I had my friends, and I had my family, but physically being alone was hard,**

you know? I was up at 3 o'clock in the morning, and then I was up at 6 o'clock in the morning, and I was up all day long. I couldn't get anything done, you know. And it was just, it was too hard; it was too much.

Finally my doula came to visit me one day, and she finally said, "Are you sure you're okay?" And I just started crying, and I said, "No, I'm not okay. I just want everybody to think I'm so strong. I want everybody to think I'm doing so good. I'm not. I can't do it. I can't. Why did I even have this baby? I can't do it." And she goes, "You can do it." She actually wanted me to come and stay at her house for a week.

I said, "No, I want to do it by myself, but I want to know that if I phone you at 3 o'clock in the morning that you're gonna be there." I was really tempted to go to her place for a week. I was. But then I thought, you know, I'm just going to start relying on somebody else to do it, and then when I go home it's just going be me again, you know? It's just still gonna be the same, so I've just got to deal with it. (B)

Participant G had her grandmother babysit her toddler for the first few days after she had her baby, then she was at home alone with her toddler and her newborn[12]. She managed pretty well with the two children; however, she did find the competing demands frustrating. Sometimes she would have to leave one child cry while she dealt with the other one's needs. The rest of the participants were living with people who could help out.

I was confident [going home] 'cause it's not like I'd never been around a baby before, so, like I knew what I was doing and everything. There were certain things that I didn't know. Like, I'm not trying to say I knew everything and I was like gonna be the perfect parent or whatever. But I knew pretty much what I needed to know at that point in time...When I'd first taken her home, I was living with quite a few people. And two people in the house. Like, there was Heather's mom and my mom in the house...So I always had somebody I could talk to if I had a problem or I didn't know what to do. (E)

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[12] Participant G was also living alone when she had her first child but her mother lived across the hall in her apartment building.

Support

As stated above the majority of participants had support immediately postpartum. Girls usually had help from one or both of their parents; however in a few cases support came from other relatives or foster families. Participant F had no contact with her family or the baby's father. Her only support was the foster family she stayed with.

> **They were great. They taught me so many things. [Foster mom]...she's a nurse so she taught me things I have to know when I become a parent and they gave me lots and lots of support. They spoiled [daughter]. They made it really good for me...Really good support. [Daughter] grew up there for her first couple months then we got our place. (F)**

Most of the participants were financially dependent on others, at least initially. In addition to financial support, participants also talked about receiving practical, affirmational and emotional support. Practical support was often in the form of childcare and came from parents, grandparents (maternal and paternal), boyfriends, and friends. Two boyfriends looked after the child while participant F and K went to school (K's boyfriend was the baby's father while F's was not). Some parents, foster families, friends, and professionals gave affirmational and emotional support. Positive comments made about their children or their parenting even by strangers appeared to increase the esteem of the girls. Encouragement and empathy were common forms of emotional support.

Some of the girls' support systems changed over time. One participant had a lot of help from her foster family for a couple months as described above, then she moved out on her own and had very little support. Six months later, her boyfriend (who was not the child's father) moved in and **"he cooks, he cleans, takes care of me, watches [daughter]...he's like a real good support."**

At the time of the interview, they had been living together for just over one year. Unfortunately, this participant could not be contacted for a follow-up interview, so it is uncertain whether her situation remained the same. Participant D initially had a large support system including her extended family, the baby's father and grandmother (with whom she lived). The baby's father had to serve time in jail, so she had no contact with him, then she moved out on her own and did not have the daily help of the baby's grandmother. Now in a couple months, the baby's father will be finished his sentence, and he has indicated that he wants to be part of his child's life again.

Changes to supports are not always bad. The participant described above prefers not to live with the baby's grandmother. Participant E who lived with her mother was able to use her as a resource when she had questions or concerns about her baby; however, the mother was also verbally abusive and would "cut her up". Finally, she left and moved in with her boyfriend.

Many of the participants identified the importance of support and need for support in their lives.

> **I learnt. I managed. I coped. I had support. That's what a lot of the girls are missing. They need support and that makes all the difference. Even if it's just, you know, a hug...that's a very big help and some people just don't understand that. That's sometimes all you need. (A)**

Although family and friends are an important source of support, sometimes these sources are limited and even if they are plentiful, additional support can still be beneficial. Three other sources of support will be discussed (1) health nurses, (2) case workers, and (3) a support group.

Health nurse

In Alberta, all mothers receive a visit from the health nurse within 24 hours of discharge from the hospital. If there are concerns or if the mother makes a request, the nurse will do more home visits. All eleven of the participants who had their babies received a nursing home visit. Only two of the girls requested more than one visit (one had two visits and the other had three visits). Seven girls liked the health nurse and four did not. A number of girls said the nurse was helpful with breast-feeding and gave suggestions and reassurance. Participant G liked that the fact that the nurse would just sit and talk for a while. Talking with the health nurse made participant B feel better about her negative birth experience. Follow-up phone calls by the nurse were also appreciated.

Some participants did not like the health nurse. Participant E found the nurse's help with breast-feeding awkward and embarrassing.

> **I had this short little nurse who came to see me at first and she made me feel really awkward because I was having problems with—like I was engorged so I was having problems with [daughter] latching on to one of my breasts. She's telling me oh twist your nipple this way. It was really embarrassing. I got over that though because they gave me a new health nurse and she went no where near my boobs at all. (E)**

Negative comments from other participants included, **"She was crabby"**, **"She tried to give advice"**, and **"I didn't like her. She told my dad he had to stop smoking in the house."** Participant D was quite surprised when the health nurse showed up at her door; her mother had not given the message that a nurse would be coming. She thought the nurse was coming back in a couple weeks, but the nurse never did come back. She wanted to contact the nurse, but she had lost the phone number and later she could not get in contact with

the nurse even when she did phone. However, most girls never tried to call the health nurse. The most common reason for not calling was that they **"didn't need her".**

Case workers

Some of the girls had home visits from two other groups, Boys and Girls Club and Terra Association, an agency serving pregnant and parenting teens. The Boys and Girls Club have an independent living program called "Turning Points". Three participants (D, E, and F) used this program but little was said about the caseworkers other than they helped the girls with budgeting. Terra has caseworkers that visit clients on a regular basis and help connect them with other services as needed. The focus group participants had contact with the Terra caseworker at school although none of them mentioned having home visits. Two interview participants (E and G) received home visits from the Terra worker. Both girls were happy with their Terra caseworker. The worker was willing to help with anything and was right there to answer their questions.

> **It was nice to be able to have somebody to talk to and come in. We didn't really talk about anything really important; you know, just about, how I was feeling and how I was doing. And, you know, how me and [boyfriend] were doing, how [daughter] was, and just stuff like that. And just, you know, doing nothing really; having just a good time doing nothing. So I found those were helpful. (G)**

Despite finding the visits helpful, this participant stopped meeting with the worker when life got chaotic with moving and having another baby. The frequency of visits seemed to depend on need and availability of both the client and the worker. Participant F had a negative experience with a Terra worker, and she did not continue to access the services from Terra. After she found out she was pregnant, she and her boyfriend met with a worker; the worker suggested they abort the baby or give it up for adoption. **"Basically I thought**

she was putting me down saying I was too young to be a mother, and I don't think that was her job."

Young mothers support group

Terra Association and Public Health jointly run a young mothers support group in an agency located in a mall. I met four of the participants at this group, which I attended for ten months. All four girls talked about how the group was a place where they could meet other young moms like themselves. They felt that they could relate to the other girls in the group and that the other girls understood what they were going through. It was a chance to get out and socialize as well as learn about other resources. Girls preferred less structure because it allow them time to talk—**"you can do whatever"**.

One negative comment about the group was that the facilitator did not have children: **"She doesn't know what it's about...I think it hinders her opinions" (B).** One participant suggested that the group focus on a narrow age range and girls of similar circumstance, such as single moms, to ensure group members can relate to one another. This girl also suggested that there be more information presented in the form of videos, books, and question and answer sessions. Despite this comment, this girl and the rest of the group focused on socializing even when information was being presented. One day three girls went for coffee after the group, and this became a weekly ritual. The group became closely knit and girls began seeing each other outside of the support group. A core group of girls which included three of the interview participants began supporting each other by exchanging babysitting, going out together, talking on the phone, and generally encouraging one another.

Participant G wished she had found a group like this earlier. She made a number of inquires about postpartum depression support groups before finding out about this one. Participant E found out about the group from her child welfare worker who worked in the agency where it was held, and her worker introduced her to the group facilitator. Participant B heard about the group from another agency but it took her three weeks to work up the courage to go. Participant A had quit attending the group after the first interview. When asked about this at the follow-up interview, she explained that she was too tired from work and did not have the time to go. She needed to spend time with her children and catch up on housework, but she missed going to the group.

To Ask or Not to Ask?

Sometimes teenage mothers do not want "help" and other times they want help but have difficulty asking for it. Almost all the participants said it was hard to admit they needed help whether it was to their family, boyfriends, or professionals. It was especially difficult to ask for help when they were new moms. They wanted to believe they could do it on their own, and they wanted to show others that they could do it.

> **It's easier to ask for help from a family member, but it's also a lot harder, because, I mean, you don't want them to know that you're needing help. You want to feel like you're doing it by yourself and that you can be proud that you're doing it by yourself. (G)**

This desire to do it on their own coupled with the difficulty of admitting the need for help and not believing that others could be of assistance prevented some girls from seeking help.

> **I'm very stubborn and pigheaded. I want to be independent. I want to be able to do things for myself. I don't want to have to constantly ask people for help. So that could have been why, you know, when I**

> **saw the unplanned pregnancy signs or whatever, that I didn't call, 'cause I wanted to try and do things on my own. (E)**

It is important that the girls feel competent and sometimes the actions of those people who were intending to be "helpful" made them feel inadequate. Participant D lived with the baby's grandma who was "helpful" but not necessarily supportive.

> **She sort of takes my job of being a mom away. She wants to change him and feed him and bathe him. And I'm sitting there getting ready to change him and she'll pick him up and change him for me. There's nothing wrong with me; I can change him. (D)**

Always being told how to do things, having their decisions questioned, and having people take over rather than just help, likely added to the participants' reluctance to ask for assistance. The manner in which help is given determines how it will be received: **"There's a way to tell people how things are done and then there's a way not to. 'Cause I don't know, it's hard enough being a teen parent, and they make you feel so insecure" (J)**

Managing Financially

In addition to fighting to become independent young adults and parents, the participants also struggled for financial independence. The household incomes of the participants varied from under $5,000 to over $50,000 a year. The girls who lived in homes with household incomes over $25,000 lived with their parents or other families. Although 8 of 11 participants who had delivered their babies were living with families during their postpartum period, only participant C and H were still living with family by the end of the study. Of the two participants who were still pregnant, one lived with her family and the other with her boyfriend's family. Most of the girls living with others still had some personal income from one or more of the following: child benefit tax

credit (~$100/month), student finance, or part-time work. All of the participants, however, indicated that they did not have enough money.

The participants who lived on their own and depended on student finance received around $850 a month if they lived in subsidized housing and around $1100 a month if they did not. While receiving student finance, most of the girls indicated that they usually had enough money for the basics but little extra. Girls who had to rely on social assistance or who worked had a very difficult time making ends meet. Participant B who was on social assistance had to live on $530 a month. Without help from her father and food banks, she would not have been able to make it. While with her husband, participant A had an annual household income of around $12,000 for a family of four. They were barely making it so she got a part-time job. Soon afterwards she and her husband separated and her household income was halved. She could not get subsidized housing because they owed money from the last time they used the service. Eventually, she was able to get partial assistance from social services but she still had to live on a shoestring budget.

In general, the participants living with family did not have to worry about basic needs such as shelter and food.[13] Personal spending money was still a problem for most of them, and they likely had to rely on their families to provide for their child's needs such as diapers and clothing. Participant C had ample money and was able to spend $200 on winter clothing for her child. Many of the girls had little extra money after rent, utilities and food, sometimes they even had to borrow money or use the food bank. Often their

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[13] Except the girl whose mother was on social assistance. Her story of how her mother spent the money on herself instead of necessities was told in Chapter 4.

babies' clothing and furniture was second hand. In some cases, girls were using older cribs and equipment that did not meet current safety standards. Two of the participants received funding from the Boys and Girls Club but they had to follow a budget given to them. The budget allowed ample money for the basics, child expenses, and clothing but only $22 a month was allowed for spending money, so the girls who smoked always ran out of cash.

Student finance

Teenage mothers get more funding from student finance then from social assistance or working a minimum wage job; however, to qualify for funding, they must take three core courses per semester. The grant they receive is usually enough to meet their family's basic needs. They can receive grant money for the entire length of their high school studies unless they "screw up". If students fail courses or quit school, they will not be eligible for the grant again, and there are no exceptions. Girls are allowed four weeks maternity leave after which they must return to school or lose their funding. These rules set many girls up for failure; having to return to full-time studies and cope with a newborn is often too much and girls may do poorly or even drop out.

Participant B wanted to do part-time studies by correspondence and stay home with her baby but then she did not qualify for student finance, and since she was over 19 years old she would have had to pay for her courses. Only participant E indicating having a problem getting student finance for full-time studies. She tried to get funding but Student Finance "screwed her around" so she gave up; fortunately, she received funding from the Boys and Girls Club. Although some girls got partial financing while living at home, participant C

said it was not fair that Student Finance did not allow for rent to parents. Participant A was the only participant not in school at the end of the study. She wanted to return to school but Student Finance told her they would not fund her because she had a full-time job nor would they fund her if she changed to part-time or quit her job. She had to continue working a full-time minimum wage job and pay for her own upgrading. This is what she understood whether or not this is true.

The major problem with Student Finance is that the funding is only for 10 months. Young mothers who are in school have little way of supporting themselves during the summer. It is very difficult for many of the girls to find a job because of transportation, childcare issues, and lack of experience. Even if they do find summer work, they receive their last student finance check at the beginning of June and need money as soon as they finish school. They cannot wait until the end of July after they have worked a month to receive money. Many girls try to stay in school and on student finance during the summer but not all schools offer summer programs and sometimes they are only for one month. Other girls try applying for social assistance but they are often refused or by the time everything processed the summer is almost over.

Social assistance/child welfare

Although most students had little difficulty with Student Finance, the consensus on Social Services was that they were impossible. Over half of the participants had dealings with Child Welfare or Social Services. Social Services only provid service to people 18 years old or older; therefore, if the girls were younger they had to deal with Child Welfare. Mothers under 18 years old are

often assigned a child welfare worker to ensure everyone's needs are being met. The girls did not see this as a source of support and help but as a threat.

> **If I say the wrong thing, I'm scared he's going to take my son away or something. And I don't like talking to them...If I don't cooperate with them. If I'm not following up to their, well if I'm not following up to my sons needs and my needs, they say that sort of thing. Just it's kind of scary. I don't know how to deal with it. (D)**

Sometimes girls need help and child welfare does not intervene. Participant E, who had a low birth weight baby, had to go back to live with her mother who spent the social assistance check on frivolous things rather than necessities. The hospital social worker did not talk to her before she left the hospital to ensure that she had a stable home to which she would bring her baby. Later when her mother was being verbally abusive, she left and moved in with her boyfriend. They applied for social assistance but since she was under 18 years old they would not fund her; they only gave her boyfriend money for himself and the child. Six months later, they could no longer afford to live on their own.[14] The girl ended up bouncing around from place to place and had to leave her baby with her boyfriend's family. She said child welfare was aware that she had no place to live and they did not help except for occasionally giving food vouchers to whomever she happened to be staying with at the time.

Only three girls ever received social assistance; four girls were denied. Participant G told Social Services she was a 17-year-old mother, and that she needed assistance until she returned to school in September. One worker told her that was fine and to complete the papers, so she did. Later, when she went for the interview, another woman told her they could not help her because she

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[14] She said they were managing financially but then they lent her mother some money and the mother never paid them back. After this they were constantly short on money.

was only 17 years old and that she had to go see Child Welfare. In the meantime she was destitute and had to borrow money and go to the food bank. A Child Welfare worker told her they could only help her if her parents abused her and that she should go live with her mother. Participant G explained that her mother had just lost her job and was living with her oldest daughter in a small apartment with five children. They still refused. The girl had to break the lease she had just signed and move once again.

Participants A, B, and C received social assistance but only participants A and B were in a situation of real need. Participant C lived at home with her parents who were able to support her; yet, someone approved her request for assistance. Later, she got conflicting information from various social service workers and eventually lost her assistance. She called her MLA and they went to see a supervisor at Social Services together. Her MLA gave them a tongue-lashing and made sure she received student finance immediately.

All the girls who had contact with Social Services said they were awful.

> **Social services I had very bad vibes from. You know they just didn't give a shit. They didn't...I swear I had breakdowns because of social services. They were just awful. I wish I had never gotten on that service at all. Like if I were to do this again. Forget it I'm not going that route again. It was bad...You know it's not even worth the money you get from them, the hassle you have to put up with. (C)**

The girls had many complaints. One, they got very little in the way of assistance. Social Services did not give a reasonable amount of funding to live on. They gave no allowance for telephone, transportation, or extras like formula nor did they even refer people to other agencies that could help. Two, it was very impersonal; the girls never met their workers. Three, when they would call their workers all they would get was voice mail, and it would take days for their worker to get back to them. Four, the workers were very abrupt

and sometimes judgmental: **"You'd tell them your life story, it goes in one ear and out the other, you know, they don't care" (C).** Participant B applied for social assistance while pregnant and the worker said to her **"My wife worked when she was pregnant".**

Being a Teen Mother

For the participants, being a teen mother had its ups and downs. It is stressful, frustrating, and tiring but it is also exciting and rewarding.

> **I love it. I do. I mean there are sometimes when I just sit and I want to cry. But I mean that happened before I was pregnant too. You know, you have bad days. But I have no regrets. Every time I look at my daughter, you know I get this glow on my face. And I'm very proud of her. And I don't care if people think that you know I am too young to be a mom. It happened let's make the best of it. You know, I'm not going to let things get me down and let it affect her. (C)**

Most of the girls' comments about being a teen parent focused on the positive aspects. They viewed motherhood as a wonderful experience and felt their children brought much joy and light to their lives. One comment from a 16-year-old mother of a newborn was more superficial.

> **I always have somebody to talk to although they don't always talk back. I can have somebody always with me, a person to take around, show off. (D)**

One negative aspect of being a teen parent was criticism and discrimination from others. Almost all of the participants talked about how strangers would stare at them and sometimes and make rude comments or criticize them.

The participants' day to day lives were very routine. Those living with family who could help with childcare had a fairly easy time compared to those girls living on their own. The girls who lived on their own had to get themselves and their child ready in the morning, walk or bus to a daycare to drop off their child, then take a bus to school. For one girl the bus ride one

way was an hour and fifteen minutes, and this had to be repeated after school. In the evening, these single parents had no break; they had a child to care for, house to maintain, and homework to do. One mother was home with her two children all day, then worked from 6pm until 2am. She had to walk home at this late hour through an unsafe neighborhood and was lucky to get five or six hours of sleep before her children woke up. In contrast, participant C who lived in an intact family had her whole family helping her and she was free to go out in the evenings: **"It's not a very stressful life that's for sure you know, and not so much that, like I still have my social life. I still have my freedom."**

The effect that having a child had on a participant's life was definitely mediated by her support system. Girls who had a lot of help were able to continue a somewhat normal teenage life such as going out, spending time with friends, dating, and so on, whereas other girls had little opportunity to go anywhere without their children. The girls talked about how having a child made them mature more quickly, become more responsible, patient, and understanding. They were more motivated to stay in school (or return to school) and do well, but they also experience enormous pressure to succeed. There is no room for failure because their children depend on them. On the negative side, becoming a parent can put one behind in school. It also makes it hard to find time for oneself. Participant G talked about feeling awkward and different after becoming a parent.

The participants felt they were doing well as parents especially since they were first time parents. Their children had all their basic needs met and were healthy and happy. Plus, they gave their children lots of love and attention. Although the girls thought they were good mothers, they liked

being told so by other people. A number of participants said they were just normal mothers; age did not have a lot to do with it.

> **I don't really see myself as a teen mom because, I mean, I'm a teen and I'm a mom, but I don't feel like a teen. I don't feel like I'm seventeen years old. I don't...I feel like a thirty-five-old housewife, I really do. But that's fine, because that's what I've chosen to do. (G)**

Although age was not part of their image of themselves as a mother, they did see their youth as a strength. Other strengths included patience, independence, being responsible, making something of themselves, and understanding their child's needs.

Concerns

Participants' concerns differed depending on whether they were pregnant or parenting. Those who were pregnant were concerned about the baby's health and labour. There was also some trepidation about having the baby: **"There's no going back. That's it. I can't put the baby back. I can't change my mind anymore."** In addition, there was concern about whether they would be good mothers. One girl was very anxious about her baby breast feeding because she knew she could not afford formula (as it turned out her baby was tongue-tied and could not breast feed well so she had to bottle-feed).

There were four common worries across those participants who were parenting: (1) making ends meet, (2) doing it right, (3) being alone, and (4) child care. Money was a constant source of stress. How were they going to pay the rent? Where is the money for next month coming from? How will they afford diapers and formula? Will the groceries last until the next check? The girls also worried if they were doing things right regarding childcare, feeding, disciplining, and just generally raising their children right. Lack of

companionship, help with childcare, and being alone were an issue for some girls.

> **Being alone now, I think is my big concern. I don't think it was my concern before...I really felt that I could do it on my own. And I probably can, you know, with no problems, but it would be nice if somebody could take [baby] at 3 o'clock in the morning and go downstairs and feed him and let me sleep for another three hours. (B)**

A number of issues were raised regarding childcare. The girls wanted to be with their children; they did not like having to leave them in someone else's care. Two girls read how important the first few years of life were, and they wanted to be there for their children. Participants feared day cares did not have enough staff to care for their children properly and give them individual attention. One girl also mentioned being concerned about abuse. Finding trustworthy childcare was an issue for some girls.

> **I would like to be able to have somebody who I can trust to baby-sit for me...I don't want her in daycare. I just want somebody who's reliable and who I can trust, which isn't easy to find. (G)**

The stress and pressure on these young mothers was enormous. They had to grow up quickly, be "good" parents, manage a household, and ensure sure they got good grades. The following participant talks about this pressure:

> **My major concern being a teenage mom is me. I got to get in gear. I got to get my school. I got to get a job. I have to get a financial stable place for my daughter to grow up in...I'm scared she's not going to have everything she needs...I'm getting scared now that I'm leaving high school which was a nice little secure click...and going into college. That's very scary for me. You know, what if I don't make it...Before it was "Oh, well, what's the worst thing that can happen." But now it's like if I screw up what's the worse that can happen. My daughter won't have a mother with a job and you know that's what gets me. (C)**

Needs

Not surprisingly, the needs participants identified corresponded to their concerns. Most of their needs fell under the broad heading of support. Since

money was always an issue, financial support was needed. Girls identified areas where they could use practical support such as housekeeping, grocery shopping (transportation being an issue), and general help with childcare. Sometimes they just needed a break from a fussy baby, time to take a nap uninterrupted, or just relax in a hot bath. Many girls talked about needing encouragement and affirmation that they are doing a good job: **"I'm going to need the support of friends and family and definitely everything positive and commending like people saying 'You're doing a good job'" (B).**

These young mothers who are always busy taking care of their babies needs, longed for friends to meet their need for companionship.

> **I wouldn't mind having a companion, you know, having a grown-up I can talk to not necessarily for anything else but to talk to. Just somebody who I'd just be a friend with, you know, have somebody who can give me opinions. (G)**

They also wanted love, affection, and caring for themselves

> **(I need) lots of love and lots of affection to me. I mean I've given that to my baby. I need somebody to give it to me. I deserve it too. (B)**

> **(I need) more support. Good support. Support that makes me feel wanted, I guess...Just to have other people prove that they care. (F)**

Numerous other items were mentioned including the need for better prenatal classes for teens, play groups for children under three years of age especially those geared to teen mothers, good day cares, day cares in schools, and transportation. In general, girls needed less stress in their lives and better ways to manage the everyday stresses.

A number of girls indicated that they personally did not have any "needs" but that teen mothers in general needed more support: **"There isn't much out there for them".** Global needs that were mentioned were:

- Teen moms should be informed of and offered services especially when they are in contact with various practitioners and professionals.
- Doctors should be more aware of available services and make referrals.
- Health nurses should visit more often.
- There should be more help the first year through community health videos and books and the opportunity to take part in question and answer sessions.
- A book written by a teen mom on what to expect would be helpful.
- There should be one central agency that girls could call that would direct them to the appropriate service, so that they did not have to make phone call after phone call looking for services.

As discussed next, teen moms also need flexible schools if they are to succeed.

School

In Chapter IV, the variation in the temporal sequence of pregnancy and school dropout was discussed. Although the girls' school experience was affected by a number of factors, pregnancy and parenting definitely impacted their schooling. During pregnancy, girls had to deal with rumors at school, morning sickness, and fatigue. In addition, some schools were not very accommodating. For instance, participant C kept getting in trouble for being late for class (because she was in the washroom being sick). One time she asked for permission to leave the classroom because she was going to be sick and the teacher said no. She ran out anyway and later got sent to the principal's office.

Returning to school after the baby was born was also difficult. First, the girls had to find childcare and as discussed above, finding reliable, trustworthy

childcare was a concern for many girls. Another problem was combining breast-feeding and school. One girl delayed her return to school because she was breast-feeding, while another who tried to go to school and breast-feed ended up switching to formula instead.

> **I went to summer school...but I was nursing, so that's why I didn't go for the first three months. (F)**
>
> **After the first month I started back to school and that's where it kind of got difficult because well I was still breast feeding her when I went back to school. So, I was breast feeding her when I got up in the morning, going to school, coming back at lunch an hour, breast feeding her again. And at the same time trying to eat my lunch. Get back to school, and then from after school on I breast-feed her for that whole time. That lasted for about a month longer. And then I couldn't really take it anymore. You know it was getting kind of hectic so I moved her on to formula for the rest of the time that she was drinking out of a bottle. (E)**

Then there was still the problem of missing school when they had been up all night with a colicky baby or when they had to stay home with a sick child.

Another barrier was school board policies. The Public School Board only allows students three years in a regular high school from when they start of Grade 10. It does not matter whether you attended during this time or not. After three years you must go to Centre High (if you are still under 20 years of age). Participant E decided against attending Centre High because it would have been too far to travel, and she did not know anyone there. She found an outreach school in the Catholic School System instead. Similarly, participant F was attending a Catholic outreach school called Fresh Start, and she was told that she would have to leave because she had spent two years there. She went to another alternative school for adults but she did not like it: **"It's lonely. I don't know anyone. The teachers take smoke breaks like 24-7[15]. Either that**

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[15] Girls have used this term a number of times. It means 24 hours a day/7 day a week.

or they're on the internet...I'd like to go back to Fresh Start." I contacted participant F's school when I was trying to locate her for a follow-up interview. They said she had stopped attending.

All the participants ended up in outreach schools because these types of schools worked better for them. There were five main characteristics of these schools that attracted them.

- The outreach schools have an informal and laid back atmosphere, and they are more personal. Students call teachers by their first names, they can move around the class freely, and they can chat with their friends. There are a small number of students and the teachers know the students and their situations. In contrast, regular high schools are big, impersonal, crowded, and teachers do not have time to get to know the students.
- They also fit in: **"Everyone's basically friends. No matter what group they're from pretty much", "The students like we all fit together. We're dropouts, and we all fit together".**
- They like the teachers because they are understanding and develop a good rapport with the students. The participants often did not like their teachers in regular schools saying they were bossy, high on themselves, and not very helpful.
- The outreach schools are flexible. There is no set timetable. Students can miss school if their child is sick. Sometimes girls even bring their children to school.
- The work is organized into self-paced modules. This allows the flexibility to work from home during the postpartum period or when children are sick. It

also allows students to set a pace that is appropriate to them. **"I didn't like listening to someone preach to you what you could learn on your own."** Another barrier to going to school was travel distance. One girl put it this way.

> **I didn't like that I had to go for an hour on the bus and the LRT and it just was a lot of work to get to school—some place I didn't really want to be anyways. It just was long and they taught me stuff that I could have taught myself much quicker you know. (G)**

There are also many barriers and difficulties in returning to school after a period of drop out. Participant B returned to school by the end of the study but it was a long, difficult, and frustrating process. In our first interview, participant B said she wanted to become a paramedic. After our second interview, we chatted about job and educational options; I suggested she see a career counsellor. Later I contacted the Terra career counsellor and found some information and passed it to the girl. About six weeks later, the participant made an appointment to see the counsellor. Next time I talked with her, she had changed her mind about becoming a paramedic because it involved too much shift work. The participant wanted to enroll in high school courses part-time but Student Finance does not give grants for part-time studies. In addition, she would have to pay for $300 to $400 a course because she was older than 19 years old and no longer qualified for free public education. If she chose to do part-time studies she would also lose her social assistance funding. Participant B was very frustrated by this point. She even indicated the stress was causing her to smoke more and that she was almost ready to give up trying to pursue education. Finally, she decided she wanted to become a respiratory therapist..

With this decided, there were a number of hurdles she had to jump. She was required to do a career investigation and attend an information session on

respiratory therapy (RT). She was going to have to do one year of pre-technology before entering the two-year RT program. Since she had been out of school for over two years, the participant wanted to upgrade over the summer before starting pre-technology in the fall. Student Finance wanted a letter from the college saying that upgrading would be beneficial for her. She asked an instructor in the program but he refused saying upgrading was not necessary. However, she persisted and was able to get a letter from the department chair. After all this, she had to take placement tests for upgrading, find subsidized childcare, and get transportation to school.

The whole process of trying to return to school was frustrating and time consuming for participant B. She almost gave up; fortunately, she is articulate and persistent. She began upgrading, although she was not happy that the school placed her at an eight grade math level. Since starting school, she had limited some of her other activities such as going out, attending the moms group, and attending church. During our last contact, she indicated that school was going "okay", and she still planned on starting at NAIT in the fall.

The one participant who was known not to be in school at the end of the study still said she planned to go back one day, but funding was one barrier (student finance told her they would not fund her because she was working). She also recognized she had to be ready to return to school if she was to succeed.

> **I want to eventually (return to school) but I got to be ready 'cause otherwise I'll just drop out again. And that's not what I want to do. Next time I go back I want to complete it. I would like for my kids to be a little older. Maybe when they're in school, I'll go back to school. (A)**

All of the participants were aware of the Terra school (now called Braemar school) for pregnant and parenting teens at the time of the interview; however, some girls did not know about the school when they were pregnant. Only participant I had attended the school. She really liked the programs that they offered on-site, but she left after a new principal came in because the school changed and became strict—more like a "normal" school.

A number of girls indicated that the school was a good program, but it was not for them. Although they liked the fact that it had an on-site day care, they did not want to be segregated with a bunch of other pregnant teens.

> **Why should I have to change everything. You know there's no law that says a pregnant women can't go to school. I think Terra is a wonderful service. I mean I understand they have a daycare and things like that. If I didn't have my mom, then probably I would have looked into Terra. But I did have my mom. And I had a chance to be in a semi-normal school you know with semi-normal people. And I choose that because that just makes me feel more normal...It just wasn't something for me. (C)**

A number of girls had heard negative comments about the school and also the day care, so they did not even consider it as an option. One girl had a bad experience with a Terra worker, which turned her off. A counsellor discouraged another girl from going to the school. One participant said she tried to get in the school but they turned her down because the semester had already started. Consequently, a number of factors affected the girls' decisions not to go to Terra school including bad reports, distance, and personal preferences.

Future

The participants wanted to make a good life for their children. They aspired to more than welfare or minimum wage jobs: **"I see all these mothers and they've been on welfare for years. Well that's not the environment I want my kids to grow up in. And I certainly don't want to stay in low**

income housing my whole life" (B). The girls' most immediate goal was to finish high school. All but one of the girls aspired to go to college. Some participants were very specific about their career choice; for example, one girl wanted to go to Grant MacEwan to take the nursing diploma, then she wanted to take neonatal training and work in neonatal intensive care. Others were more general (e.g. "business", "counselling") while a few girls were still undecided. Most participants did not see any barriers to achieving their goals: **"None, if I set my mind to it."** Two girls said funding could be a barrier and one identified grades as a possible problem.

In regards to their personal lives, ten girls said they would eventually marry. Participant C indicated she would like to marry her current boyfriend. Participant D and F said they would never marry; although, participant F also said she would want to be married if she had another child. Participant A had already been married, was getting a divorce, and marrying another man. At the time of the first interview this participant had also said she was happy with two children and did not want anymore. However, at the follow-up she was trying to get pregnant with her new fiancé. Participant K said she wanted to have another child within two years. The remainder of the participants wanted to have more children but not for a long time.

I asked the participants if they were taking precautions not to get pregnant again. Participant G stated, **"I've met some people but even when I'm drunk I tell people 'I'm not having sex again until I'm in a loving, committed relationship with the man I'm going to marry'" (G).** Participants D and I also indicated that they were not sexually active but that they would use condoms if they were. The rest of the participants were sexually active.

Participant B started on birth control pills after her abortion, participants C and J were also on the pill, and participants E and H used condoms. Participant K, who wanted to have another baby within two years, wrote on her information sheet that she used condoms or nothing. When I spoke to her a month later to clarify some information, she stated that she received a Depo-Provera shot[16]. Participant F revealed after the interview that she was not using any contraception with her live-in partner even though she did not want to get pregnant again. She said she did not like the pill because it "messes up your system". Participants L and M were not using contraception as they were pregnant.

Although the participants had thought a bit about their future in terms of career, marriage, and future childbearing, they focused their energy on the immediate future, which was completing high school. The one girl who was not in school was focused on her children and their adjustment to all the change in their lives.

Themes

Although the study sample was diverse with regards to age, ethnicity, family background, and current living situation, there were many similarities in the participants' experiences. From "Finding out" to "Future", the participants talked about similar issues, concerns, and needs. Moreover, there were common ideas and topics that reoccurred in the data from the interviews, observations, and conversations with professionals who interact with teenage mothers. These themes will be explored next.

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[16] A contraceptive injection that lasts for three months.

Perceptions: "I believe..."

Some common perceptions held by the participants and other teen mothers emerged during interviews and informal conversations. Knowing what these girls believe and think can help interpret and understand their behavior. Some of these beliefs were alluded to in the pregnancy and parenting sections but will be expanded on here.

It's better to parent when young

Five participants directly stated that they believe their youth is a strength when it comes to parenting and gave reasons why it is better to parent when young.

> **That I'm young 'cause I'm still able to learn, still able to grow with my child and stuff like that. I'm not stuck in my ways like an older person would be...I think also the older you get the more baby dumb you get because you're reliant on your career and on your husband...I think the younger you are the more open you are to knew ideas and new ways of raising a child and discipline and the more adaptable you are. Way more adaptable. The older you get, you just forget. And you forget what it is like to be young too. (B)**

They felt because they were young, they could relate better to their children. They could understand their children's needs and frustrations better, and they were more relaxed and laid back with their children.

> **I'm still at the teenager stage where I still want to act like an idiot you know play around and be goofy and everything. It's kind of more laid back. I think [daughter] enjoys that more than if she had parents like [boyfriend's] parents you know real staunchy people. (E)**

Other comments were that teens can remember their childhood, they can anticipate things a child might try to do, and they are more tolerant.

For some girls it was not that being a young parent was better but that being a young parent was not necessarily worse. Participants were upset that others assumed they would be bad parents just because of their age. During

one coffee session, the girls talked about how they were just as good parents as many older women and in many cases even better parents. Age had little to do with whether you were a good parent or not, maturity was a better indicator. Some 30 year old women act like 16 year olds while a lot of teen mothers act much older than their age taking on the role of mature, responsible adults and parents. Although a number of the participants and other teen mothers that I interacted with seemed to hold this view, it is not possible to know whether this was a belief they held before having a baby or whether they developed it as a partial justification for being a teen parent.

I am a good mother and having a child has positively affected my life

In addition to feeling that there were some benefits to parenting at a young age, all the participants found that becoming a mother positively affected their life.

> **If I didn't have her (daughter), I wouldn't be where I am today. I wouldn't be this far. I wouldn't have as many goals and stuff...I wouldn't be in school. I highly doubt that. I smoked a lot of drugs before I had her; I'd probably still be doing the same thing and wouldn't care, wouldn't have any goals...I think it's for the best...It's just another reason to make the best of myself. (F)**

Participant C also said having a baby motivated her to finish her school. One year she was essentially a school dropout, having received only five credits the entire year. The next year she completed 66 credits. A number of girls mentioned how they matured more quickly and became more responsible, and those who were into the party scene stopped partying. Participant A said that having children made her a better person.

The other positive effect on their lives was the experience of being a mother. Talk to virtually any mother and they will tell you that although

children can be trying, they also bring so much joy into one's life. The teen parents had the same sort of experience.

> **You know like when I'm having a bad day and I come home to her and she's like chewing her blanket and drooling or something. It's just everything she does can just bring so much light to me. (C)**

The majority of participants perceived mothering as a wonderful and joyful experience. It gave one girl a sense of accomplishment—being a mother became part of their identity: **"I don't remember what it was like not to have (a child). I really don't" (G).**

All participants felt they were good mothers, but it is unlikely any of the participants would have come out and said, "I think I'm a bad mother". Although they were not perfect parents, their words and actions showed that they were adapting reasonably well. In spite of the fact that finances were very limited, the young mothers all made certain their children's needs were met. The children always came first; this meant buying diapers, formula, baby supplies, and children's clothing first, then making do with what was left and sometimes going to the food bank or asking family for help.

> **The kids come before anything else. I don't care what I have to give up as long as the kids have what they need" (A).**

> **I'm more worried about whether or not she's [daughter] gonna have enough diapers to last till the end of the month than I am about whether or not I'm going to have the newest type of makeup, you know. So I think more of her than I do of myself (G).**

Not only were the children's physical needs put first, but their emotional well-being was also a priority: **"I'd spend that day just me and the kids, especially after (husband) and I separated. I wanted a lot of quality time with just me and the kids. They needed that" (A).**

In general, participants did not like being away from their children—having to leave them in the care of others. Participants B and G mentioned how important the first years of life were, and they wanted to be there for their children. Participant G found a school that would let her do her schoolwork at home, so that she could stay home with her baby.

> **I like being a full-time mom. I like being able—you know when she cries I can hear her and I go and get her...I wanted to make sure I was going to be able to cuddle her and be the mom I wanted to be...I just think it's better for me to stay at home with her. (G)**

Participant A worked, but she talked about how she missed the time with her children. She missed the little things like tucking them into bed.

Six of the interview participants read a lot about parenting and childcare. One mother would read about the stages her children were at and compare their development to what the book said. At the support group, the facilitator would bring books from the library and the girls would borrow them. Participant B would go to the library herself every week and take out a stack of books. As her child got older, one mother described encouraging her child's speech and learning.

> **We try to say sentences to her to get her to speak in sentences 'cause she's almost two...There's a park next door that we bring her to just to play. We don't play with her toys much it's always other things to teach her. (F)**

Overall, these young mothers believed they were doing a good job of raising their children for first time mothers under sometimes difficult circumstances.

<u>I can only relate to people of similar age and circumstance</u>

The participants in this study, like most teenagers, felt they could only relate to their peers and that only someone their own age could understand them. The reality was that once they got pregnant and had a child, their peer

group was no longer teenagers but instead pregnant and parenting teenagers. **"I could talk to (my friend) but she couldn't relate. You know, she hadn't been pregnant. She didn't know exactly what I was going through" (E).** Although most girls continued friendships with non-parenting friends, they also developed new friendships with girls who were parenting.

Despite wanting to talk about what they were going through with regards to their pregnancy or parenting, the participants did not feel they could relate to older mothers. "Older" to the participants seemed to be women over 25 years of age. A number of comments were made about how they would feel out of place in groups with older women. Part of the problem was that these "older women" tended to be married or in partnered relationships while many of the participants in this study were single. Being single also made the girls uncomfortable in prenatal classes. The teens also had different issues and concerns than older mothers; they were still in high school, dependent on their parents, and dealing with adolescent issues. One girl commented that older parents think they know it all. Teen mothers feared that older mothers would judge and criticize them.

Age is not the only factor that affects girls' ability to relate. As noted above, participants preferred to talk to friends who had also experienced a pregnancy. This also applied to their interactions with professionals. Some girls would rather meet with professionals who had children of their own because the girls felt these people had a better understanding of what they were going through and could give more pertinent advice. Other life circumstances were also important to relating. One participant suggested that support groups focus on very specific ages and circumstances. For example,

she felt that a married mother would have different resources, supports, and issues and would not be able to understand the concerns of a single mom. Another participant explained that she had not attended groups because she could not relate to the other girls.

> **The teenagers in there a lot of them were on their own. Their parents had kicked them out and I didn't fit into that category of the kids in my group. So, I felt bad going in there and they're talking about "Well, we have a free baby auction you can come in and pick up a stroller for 10 bucks." I was able to go out and buy a $100 stroller. And I don't want to say stuff like that in front of them. Like I want to encourage them and say good for you. But I have it so well, I just felt bad being there. You know like I was living with my mom and I was happy about this. I couldn't wait and everyone else was crying "Oh, my mom hates me". Oh God! It was more depressing for me than anything. (C)**

I get criticized, judged, and treated differently

All participants had people in their life that they felt understood them; unfortunately, they felt that more people were critical and judgmental than understanding. Girls seemed to be bombarded by criticism everywhere they turned—from strangers, school staff, professionals, and even their supposed support people. By far, strangers were most rude. As soon as girls were noticeably pregnant, they would get stared at and people would whisper behind their backs. They could hear people making comments like "She can't be more than 15 or 16. I think that's just disgusting." Often strangers would walk right up to them and say things like "I can't believe you kids these days" and "Why didn't you get an abortion?" Or, they would get asked if they were babysitting. These comments hurt, but the girls dealt with them the best they could.

> **I just try not to listen to people who criticize me because it just makes things worse. And it just makes me feel bad and then it makes me wonder and question myself and question my abilities. (B)**

One girl talked about how her second pregnancy was even harder.

But with the second one it's like you're looked upon as, almost like a slut because you just got pregnant again. What's wrong with your head type thing...I feel almost ashamed when I walk through a mall with (my daughter) with my, you know, my stomach sticking out...I don't look seventeen...until I get older it's always going to be a gawking scene for other people, like "See kids, that's what can happen to you if you have sex. (G)

In school, girls had to contend with stares, rumors, and other students talking behind their backs; plus, teachers were not always very understanding or accommodating. Furthermore, professionals sometimes did not act professionally; they let their prejudices show. One doctor walked out and did not finish a girl's exam. Some nurses were rude and their actions if not their words seemed judgmental and critical. Participant A was very upset because the nurses would not let her hold her baby following delivery. She believed they did not think she was competent. This girl also felt that the nurses were rude and impatient with her and another teen mother but not with the older mothers in their room. Two participants described how their social workers had bad attitudes toward them—**"She was always, 'Why can't you get a job?' I said 'Well, I'm going to school.' You know it was kind of the attitude, 'Well, you should have thought of that before you got pregnant'" (C).**

Unfortunately, many of the girls even felt judged at home by those people who were there to support them. Comments that were probably meant to be helpful made the girls feel like they were being judged and that they were incompetent. Too often "support" people gave only negative feedback such as "You're doing that wrong", "Here, do it this way", and "Don't forget to burp her". Their actions also made young mothers feel inadequate. A number of participants said their parents or "helpers" would just take over and do everything. This type of "support" made the girls reluctant to ask for help.

I Want To Do It By Myself

Most of the participants admitted that they needed support, yet they strove for independence. They wanted to do it by themselves. One reason for wanting to do things on their own was to show others that they could do it. It was almost as if they felt they needed to prove they could be a good parent. **"I want everybody to think I'm doing good" (B).** Another reason was that participants needed to feel competent. **"I want to believe I can do it myself" (A). "I need to feel I can provide for her" (C). "You want to feel like you're doing it by yourself and that you can be proud that you're doing it by yourself" (G).** Participant F said one of her strengths was how independent she was while participant D said **"to live on my own instead of depending on other people"** would help her be a better parent. A third reason was that participants did not want to be dependent on others. **"I don't like having to rely on everybody" (G).** Participant B talked about having to get used to doing it by herself anyway. It was as if they did not believe others would always be there to help them when they needed help. A few of the participants also mentioned that they did not want to rely on their baby's father for child support because they would be at his mercy.

Barriers to Service Use

Sometimes the participants desire to do things on their own prevented them from accessing services; therefore, this attitude could be a barrier to service use. Barriers are those factors that make it difficult for people to use services. Internal barriers are beliefs, attitudes, and experiences within the individual that stop him or her from using services. Environmental factors and

characteristics of the service or program that affect use of that service are external barriers.

Internal barriers

The participants gave a variety of reasons why they did not use some of the existing services and programs. A common internal barrier was thinking they did not need any help. Sometimes the participants felt they were doing fine without the help of a certain service or program, or they did not feel it was important as in the case of prenatal classes. One girl put it this way: **"I knew pretty much what I needed to know at that point in time."** Even when some of the girls were in need of intervention (e.g. they were in an abusive relationship or lacked basic necessities); they did not think to call someone for help or they did not think there was someone who could help them.

Time was also a barrier. One participant said she did not go to the doctor until she was four months pregnant because she was busy with school and work when she was not throwing up or sleeping. Another girl did not attend the groups and classes that the family support worker would invite her to because she had other priorities. She preferred to spend her time with her daughter or her friends than a bunch of strangers who happened to be pregnant or parenting. As mentioned earlier, feeling you can relate to others was important; just being a teen mom was not enough in common. Plus, if she had any questions or concerns, she knew whom to call.

A number of participants mentioned being turned off services by bad reports, experiences, or feelings. Examples were given earlier about how girls ruled out going to Terra school because they had heard negative comments about it or had a bad experience with a Terra worker. Although only one girl

explicitly talked about being scared, fear was likely a factor for a number of girls especially when it came to using government services such as child welfare, social assistance, and public health. They expressed the fear that these people are checking and will take away the child if the mom "screws up". One participant also talked about how teens may be scared to use services because of what people might think of them, how people will react to them, and whether people will take them seriously.

External barriers

Numerous external factors added to the barriers that the girls already had internally. The biggest barrier to using services was not knowing about them; they were not well advertised. Plus, the professionals they did have contact with did not provide much information on other services. **"They don't offer you services. Social assistance offered me nothing. Nothing. They didn't even tell me I could get hampers. Nothing" (B).** Most of the participants, however, did not ask about other services. **"I didn't know there was anything like that, so I didn't think to ask. I just found out about this stuff a couple of weeks ago" (E).** Even when they wanted to find a particular service, they did not know **"where to look, who to ask or what to do."**

For example, participant G made many calls looking for a postpartum support group for young moms: **"I had to look really hard to get any information on a teen group at all."** If the girls had friends who were pregnant and parenting, they sometimes found out about programs and services from them. Some girls received information from school counsellors, but many of the girls were already out of school when they got pregnant or they dropped out without talking to counsellors first. Even when participants

did talk to counsellors, limited information was provided. Moreover, the counsellors usually only told girls about services; they did not actively connect girls with services. At least six of the participants spent most of their pregnancy just hanging around the house, so getting information to them would have been difficult. **"When I was pregnant, I very rarely left the house. And I wasn't going to school so I didn't have those kind of resources" (E).** The girls said that one way they could have received information would have been through their doctors. Another way would have been for a worker to visit them in their home.

Knowing about services did not mean participants could access them. Most of the participants had limited financial resources, so if there was any cost associated with accessing a service they were often not able to use it. Cost was the reason why two girls did not take prenatal classes; they did not know there were ones free of charge. One girl put it this way: **"If you have to pay for something, you kind of think 'Well, do I really need this?' Health for two, you walk in there. It's free. You don't like it, you leave. You didn't lose anything" (C).**

Distance was another barrier. If the service was not within walking distance, then transportation was required. For most of the girls their only source of transportation was the bus, which cost money. Furthermore, it was not always easy to travel to specific places using the transit system, and it was a lot of hassle to have to take children with you on the bus especially in the winter. Too often the services had business hours, which did not work well for working mothers or mothers in school. For example, one mother was trying to reach Social Services before they closed for the Christmas break, but she

worked during the day and could not afford to take time off work. To reach the Social Services office, she needed to take two buses with her two children and then wait there for an indefinite period of time to see someone. Another girl had a similar problem accessing a subsidized housing agency.

Importance of Rapport and Relationship

Not only was service use affected by the barriers discussed above, but it was also influenced by rapport and relationship. Teens are often nervous and anxious when they phone or walk into an office for information or use a service. If the office and staff do not have a welcoming and friendly atmosphere, the teen may walk out before getting help. Walking into a strange office can be very intimidating for anyone and more so for a pregnant teenager or teen mother. They do not know what they should do or what to expect. The staff must help them feel at ease and be helpful and caring, otherwise the girl may not return.

Some of the participants had negative experiences with agencies. For example, two girls who went to different agencies to get "Health for two" milk coupons described walking in and not being greeted. Everyone was busy. When they told someone why they were there, they were given the coupons and told to let the agency personnel know if they needed to talk. The staff person spent very little time with them and was not too friendly or inviting. The girls got very little help from these agencies, and they did not return to them. The experience of the focus group participants, who were attending an outreach school, was very different. They had a family support worker (FSW) come to their school which was a familiar and safe environment to deliver "Health for two" as part of a teen parent support program. The FSW was friendly, helpful,

and encouraging. She developed a good rapport with the girls, taking the time to sit and chat with them about how things were going. One girl said, **"You got to know the people. You got to get a little more personal with them."** She also said the fact that the FSW would call and invite her to programs although she did not go, showed that the FSW cared and did not forget about her.

Many of the participants had ongoing contact with a number of professionals such as social workers, doctors, nurses, and teachers. The perceived helpfulness of these people depended on their ability to establish rapport and develop a trusting relationship with the participants. The social workers who the participants had contact with were described as being abrupt and judgmental. The girls rarely even met their worker face to face; there was no rapport. **"These people sit behind their desk and stamp your file and that's it. They don't know you. They don't care" (C).** Participants' experiences with doctors varied. Some girls said their doctors were friendly and took time to talk with them while others were distant and rushed.

> **He wasn't very talkative. He jut walked in, did his stuff, walked out. He didn't answer my questions, and I didn't like him enough to—I felt like I was bothering him to ask any questions. (G)**

It meant a lot to one girl that her doctor remembered her and her situation when she called him because she was having premature labour. He met her at the hospital, took her to her room, and examined her immediately. On the other hand, several participants were upset when their doctors did not deliver their babies. They spent nine months with their doctor had developed a certain level of rapport and trust. Then suddenly when they were in labour, which of course was a very stressful and fearful time, a doctor they had never met came

in to deliver their baby. This doctor did not know them or their history, and consequently, asked numerous questions, which irritated them even more.

Establishing rapport with teen moms requires effective interpersonal skills including the ability to relate to this generation. Sometimes the girls preferred talking to someone close to their age. For example, participant C talked to the youth worker at her school more than anybody else. **"We go for our smoke breaks together and I sit there and I tell him everything as if his is my counsellor down to the very personal details of my life."** She felt he understood and was being "real" not "fake". This informal "chit-chat" time is often what created rapport and relationship. Once a trusting relationship had been developed with someone, the girls felt safe going to that person when they had a problem.

Personality had a lot to do with rapport. There were two facilitators at the young mothers support group—a public health nurse and a Terra caseworker. Due to time constraints, they decided they would alternate weeks rather than facilitate together. The participants who attended this group did not like this new arrangement and did not want to go when the public health nurse was facilitating. The same situation can occur in school. If a student does not get along with a teacher, he or she may not go to that class. **"If I didn't like my teacher, I just wouldn't go to class. Period" (B).**

Rapport and relationship were also important factors in referral. A teen mom was more likely to go to a program or service if she had a positive relationship with the person who was recommending it. However, they were most likely to go if a person they knew and trusted was the one who connected them with someone at another service. Passive referral or just telling someone

about a service was not very effective. Participant B was told about the young mothers support group by an agency. It took her five weeks before she worked up the courage to go to the group. Participant E was referred to the group by her child welfare worker but her worker took the time to introduce her to the support group facilitator. This type of active referral appears to result in higher accessing of services by girls. The coordinator of the teen parent intervention program twice made an appointment for a pregnant teen to go on a hospital tour. The coordinator had planned to take her to the hospital but got busy and was not able to; the girl said she would go by herself, but she did not show up for the appointment. Finally, the family support worker was able to take her. The girl later said she would never have gone on her own because she did not know where to go or **"who the heck"** this hospital social worker was.

Where are the Daddies?

The participants' relationships with the baby's father did not last. Furthermore, it was common for the children of these teen mothers to have absentee fathers. There were 13 parenting outcomes in the sample plus two girls who were pregnant. Eight of the thirteen relationships ended before the participant gave birth. Ten of the thirteen children had little or no involvement with their fathers by the end of this study. The two participants who were pregnant were still in a relationship with the baby's father (see Appendix L).

Six of the fathers were never involved in their children's lives. The involvement of the remaining fathers often changed over time. Participant A's husband ended his involvement with his two children when the relationship with his wife ended.

> **He wants nothing to do with his children whatsoever, so he gave [my fiancé] every opportunity. He said, "We'll sit down; adopt my children." (A)**

The father of participant D's baby was involved throughout the pregnancy and was present at birth. His involvement stopped at two months postpartum when he had to serve time in jail (although he wants to be involved in his child's life once he is released). Participant E continued to go out with the father until their daughter was two years old. She explained why she ended the relationship.

> **He's getting too involved in this—well, involved at all is too involved—in the whole drug scene. Like, [boyfriend] smokes up, and when [daughter] was living with him he would take her out with him. He was involving my daughter in it. Like, he would take her over to his friend's house or whatever, they'd smoke a joint, and then he'd try to go on the bus with her late at night, ten, eleven o'clock at night. And it got to the point where every time he came over here to visit her, he was fried. He showed up for her second birthday fried; he was just stoned out of his face. (E)**

The father was very involved in the child's life, as he had lived with the child and participant E for six months. Later when the mother did not have a stable home, the child lived with him and his parents for six months. However, in my last interview with the participant said this about his involvement.

> **It was pretty good for a while. He was coming to visit her on a regular basis, but now we've gone back to the usual where he very rarely comes to see her. (E)**

The father of participant G's second child had minimal involvement with the baby a few times a month, but he does not really spend much time with the baby during the visit.

> **He comes over. He sits on the couch, puts the remote in his hand, flicks the channels and eats my food, you know, makes my house a mess. But he holds him (baby) for maybe a half an hour visit. He doesn't really change him. He doesn't really do anything with him. (G)**

The father of participant H's child did not have any involvement with the child until she was three months old, but he has had custody of her since she was one year old (against the wishes of the mother). Participant K lives with the child's father and the father cares for the child while she goes to school.

Eleven of the fathers do not currently live with their child and should therefore be paying child support but only one father gives child support on a regular basis. The father of participant E's child gives 15% of his wages for child support; however, he was unemployed for a long time and did not give any support during that period. Participant A said that she does not want her ex-husband paying child support because she does not want him to have anything to do with the children. Participant G has asked for $100 a month from her baby's father but only receives money sporadically.

> **He knows I expect $100 a month...He says, "Well, I have car insurance and I have phone bills."...I don't expect anything if he was just to leave and never come back. I don't expect a dime from him then. But if he's going to be part of [son's] life and you know come over every 12 days or whatever, then I do expect something. Because if he is going to get the rewards, he should pay for some of it to. (G)**

She does not, however, want to take him to court: **"It seems worthless because we're on fairly good terms and I don't want to ruin that. I don't want to ruin it for [son]."** Another reason she is not persistent is because she receives on student finance. She is required to report any child support money she receives, and it will be deducted from her grant check. As mentioned earlier, the girls do not rely on the fathers to pay the child support because they may not always pay it. In addition, the process of going to court seems overwhelming for these girls who already have limited time and resources.

Unhealthy Pattern of Relationships

Another theme is the unhealthy pattern of relationships that many of the participants have experienced. Relationships seemed compressed for the participants. For example, sometimes girls would go out on a couple dates with a man, have sex, and then sometimes ended up living together, all in less than a month. Relationships were often short term; and a few weeks (or sometimes even a few days) after ending one relationship, they would be in another.

For instance, participant A left an abusive relationship after she had two miscarriages, then she started another relationship and was soon pregnant again. She married and had two children. One month after her marriage broke up she was already engaged and living with another man. Participant B had four pregnancies in five years with four different men, and these four relationships not all of her sexual relationships during that time. In the six months after her son's birth she had at least three different sexual partners. Participant G began dating her second boyfriend during her first pregnancy and ten months later was pregnant with his child. They eventually broke up too. Only two of the participants who started new relationships after becoming pregnant have stayed with their new boyfriends. Participant F's new boyfriend even babysat and cared for the child all day while the mom attended school. Participant C said she planned on marrying her boyfriend.

> **He was with me during my whole pregnancy and we started dating after she was born. He was there for the whole thing in the delivery room and everything. And I guess I think of him as my best friend. And last couple of months we've been staying at each others house back and forth. My boyfriend, in my eyes, he is [daughter's] father. (C)**

Four of participants had boyfriends (who were not the baby's father) live with them from one month to over a year. Less than two months after having a baby Participant B let a man she had only been out with a few times move in with her. At the time he moved in, he had no job so he did not contribute to the expenses. Most of their sexual activity was unprotected although the participant had free access to condoms. About a month into the relationship, they were talking about marriage and having a baby together; however, the relationship changed from week to week. One week she was madly in love and the next she could not stand him anymore. Here is what she said about the relationship.

> **It's still my house. I still pay the bills, and I can kick him out any time. But I kind of enjoy having him around 'cause he does do a lot of things. He makes formula...he cleans up, and he does the dishes, and he cooks and, you know, sits here while I go and have a smoke outside or, you know, gets things for me...So it's kind of nice having him around, but at the same time it's really different. And I'm not sure whether I'm just being hard on him because I'm used to being alone, or whether I'm being hard on him because I just don't like him...I just want him to be there for me, do what I ask and shut his mouth, and I'll take care of [baby]...And I know that's so horrible to say, but that's how I feel. You know, it's nice to have him around to do things. (B)**

It sounds like she was just using him but then again he had the benefits of a place to stay for free and a sexual partner. She broke up with him saying she never wanted to see him again, yet when she found out she was pregnant with his baby, she considered marrying him. In the end, she chose to have an abortion.

Participant F's boyfriend moved in with her. He did not have a job, and instead of finding one this man took care of her daughter while she went to school. Although if she could find a good day home, she said she would like him to find a job. In the meantime, he was a high school dropout living off his

girlfriend. Participant K had a similar arrangement with her boyfriend who was the child's father. Participant A had her fiancé living with her. He worked full-time but it was unclear how much he helped out financially. She was engaged to him after only knowing him a few months; her children were already calling him "dad". Yet, she said she had never discussed her education or career aspirations with him.

Participant G started dating a new boyfriend while she was pregnant. He soon was spending nights at her place although she did not consider this living together.

> **Well, we were not really living together. It was—he's never actually lived with me. Like, it was just** [I: He would stay over now and again?] **Well, not now and again. It was like we were living together but his stuff wasn't there. He didn't help pay half the rent. It was just he would give me, you know, if I said, "Can you give me fifty bucks from your cheque?" he would give me fifty bucks. Or once in a while he might go and split half the groceries with me if he's been spending a lot of time there. But I mean, all his stuff has always been at his parents, so it wasn't like he actually moved out when we broke up. It was just like, you know, I'm taking my alarm clock and my clothes. (G)**

Even though he was not "living" with her, he expected her to do his laundry and have the house clean for him. He played dad to her baby but did not want to take any of the responsibility of childcare.

> **I wanted to be a mom. He wanted to be called a dad, but didn't want to do the dad work. You know I think he bathed [daughter] once. He changed her diaper not even for the first time till she was like six months old...He would play with her but when she got tired or dirty or cranky or anything, it was my baby, you know. (G)**

The participant got pregnant by this boyfriend when her baby was about ten months old. They broke up before the baby was born. He sees the baby sporadically, but he does not take an active role. When he did come by it was usually late at night and then he expected to spend the night. The participant

let him sleep over in her bed on a number of occasions. She said **"I was beginning to feel like a slut in my own house"**, so she finally told him that it was not acceptable for him to come over late at night or sleep over.

These young mothers need relationships that are supportive and helpful, yet the relationships they become involved in often add more stress and complication to their lives. One young woman talked about how having a boyfriend just added more stress to her life.

> **So I think I'm starting to get a little more organized, but now with [my boyfriend] in my life, there's just so much more stuff, you know, and it's like I could barely handle just me and the baby stuff. Then with me and [the baby] and [boyfriend], I think I'm more stressed out with [boyfriend] in my life than with just me and [the baby]. Almost too much to handle. So I don't know. I like [my boyfriend] and all, but sometimes he just fucking gets to me. (B)**

A baby takes a lot of energy and many of the girls did not have the time to invest into maintaining and enhancing their relationships. Or, after getting pregnant some girls realized that the relationship they had with the baby's father had little future and they were better off without him.

Many of the participants' relationship appeared to revolve around sex except participant C's. She talked about her boyfriend being her best friend. There was little foundation or depth to the relationships, and they tended to crumble easily. One might argue that some of the men were taking advantage of these single teenage mothers but then the girls were also "using" the men to some degree to meet their needs. Overall, the pattern of short-term sexual relationships is unhealthy for both these young women and their children. These types of relationships seemed to put them at greater risk for repeat pregnancies and the transient nature of men in the lives of their young children might have harmful effects.

The participants' stories have been presented and common themes from their stories have been discussed. These findings provide valuable information about teenage motherhood as experienced by these girls. In Chapter VI, this vast amount of data is reflected on from the dual insider/outsider perspectives to gain insight. The data are given structure; then they are recontextualized with existing knowledge about teenage pregnancy and motherhood. First, I present my reflections on the findings.

Reflections: Style and Unexpected Findings

Ethnographies are most often written in a narrative format, but they can also be presented as a chronology or described using a thematic approach (Boyle, 1994). I chose to present the findings of this study as a chronology along with a number of themes. There was a vast array of findings covering a number of topics, and I wanted to report as many of the findings as possible. The participants' stories were essentially a chronology or natural history, so this approach was a good fit. I wanted to keep the individual elements of their stories and not force them into a composite narrative. Furthermore, I felt that this format would be more useful and appealing to practitioners. Presenting the girls' lives in chronological segments does lose some of the impact and complexity of their stories because the whole story of each participant is not presented. However, Chapter VI includes a fictional story created from events in participants' lives to illustrate the complexity of influences on teen mothers' experiences.

Some of the findings were surprising to me. I was not expecting participants to be so positive especially to describe enjoying their pregnancies and wanting another baby. It was surprising to me that some girls' parents

were happy when they found out about their daughter's pregnancy. Although I understand that becoming a grandmother may be exciting, I did not think that happiness would be a parent's initial response to his or her 15-year-old daughter's news of pregnancy. I was somewhat surprised that the girls read as much as they did even the participant who had only completed Grade 8. As I surmised in Chapter III, the participants preferred outreach schools to traditional school environments. I was happy to see that the girls were fairing well in outreach schools, as an unstructured self-paced environment does not work well for all students.

The amount of interest in spirituality and church was another surprise to me. One girl indicated she had some ties with the Catholic Church while another attended a Christian church with her foster family. Two other girls talked to me about their interest in finding a church to attend; yet they feared that churches would react negatively to their status as teenage mothers. This interest was encouraging because it meant that churches could likely be another source of support for teen mothers if they got connected with one that was friendly and accepting. The situations with the fathers saddened me. I am angry that men can father children yet have no consequences; they can just get up and leave their child and the mother as if nothing ever happen. On the other hand, I was impressed with the participants. They were trying to be the best parents they could be in difficult circumstances.

Chapter VI

DISCUSSION, CONCLUSIONS, AND IMPLICATIONS

Ethnographic methods were used to examine the experience of teenage motherhood in context and explore concerns, issues, and needs from an emic perspective. A wealth of findings that describe teenage mothers' past, present, and future were presented in the previous two chapters. In this chapter the findings are reviewed in the context of existing literature. Through the cognitive process of theorizing, a model for organizing data emerged. This model will be used as a conceptual framework for organizing the discussion. Conclusions that are related to the research questions follow the discussion. Next, implications for practice, recommendations, and suggestions for further research are outlined followed by reflections on how the study relates to health promotion. The strengths and limitations of the study are then presented followed by a summary. Lastly, I share my reflections on the research process.

The Model

Upon intensive reflection on the categories and themes that emerged from the data, "relationship" surfaced as the core factor. "Relationship" was an important aspect in all categories and themes whether it was the relationship between the teen mother and another person or between the individual and her environment or even the relationship between two or more factors. The chapter on context, for example, is about the girls' relationships with their family, boyfriends, and schools plus the relationship among personal factors such as development and resources. Concepts and categories related to pregnancy and parenting such as "sharing the news", "options", "support", "services", "adjusting to motherhood" are also all impacted by relationships.

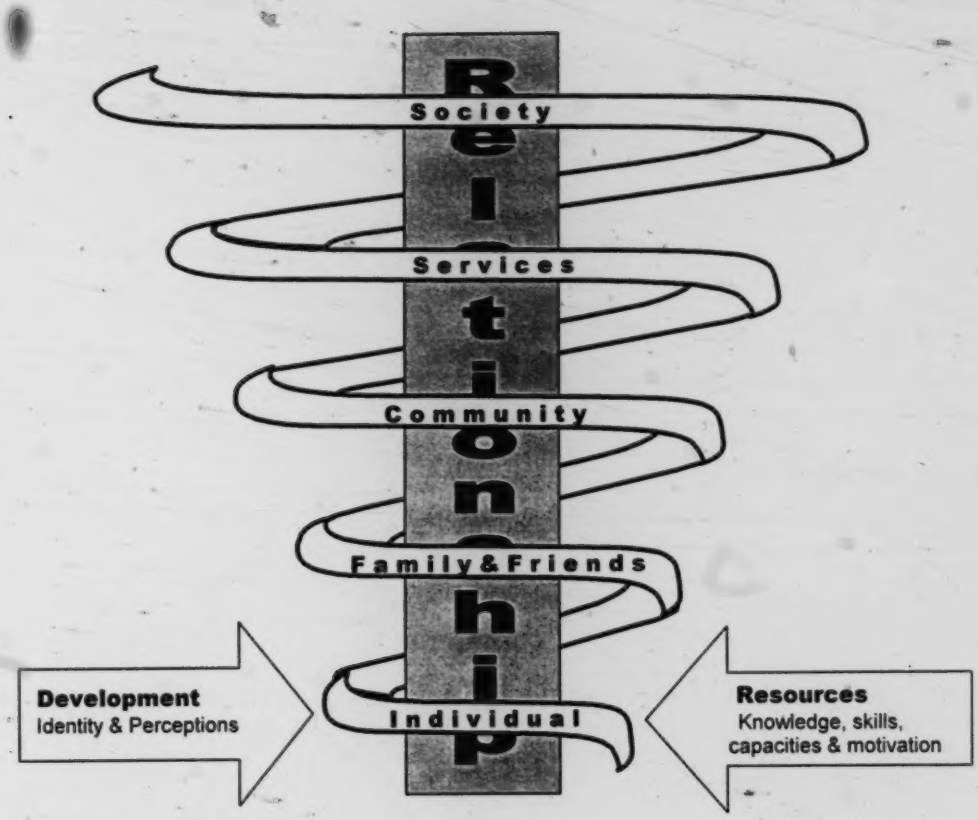

Figure 1 Model of influences on the experience of teenage motherhood

It has already been established that teen pregnancy is a complex issue involving a number of interrelated factors; therefore, it cannot be understood by analyzing only individual factors; environmental factors must also be considered. The environment can be viewed as a hierarchical framework where one system is part of a larger system, and there is a dynamic interplay and interdependence between systems. Pregnant and parenting teens are embedded within a number of systems that have a cumulative affect upon them. Teenage mothers relate to and are influenced by their individual characteristics, family and friends, community, services, and society.

Teen pregnancy and the experience of teenage motherhood for an individual teenage girl are influenced by a number of personal factors such as development and resources. Having a child during adolescence may throw girls into adult roles, but it does not mean they have reached maturity. Therefore, issues related to development have an impact not only on risk of pregnancy but also on parenting. Another influence on the individual is that of personal resources, which are those things that individuals have within themselves such as knowledge, skills, capacities, and motivation. These resources affect teen girls' use of contraception, their pregnancy decisions, and their ability to cope with parenthood.

Individuals experience life as part of families and circles of friends that involve patterns of relating, attitudes, values, and resources. Individuals and families function within a community that may be a geographical setting such as a neighborhood or people linked by something in common such as a peer group or school. All three of these systems relate to various services provided in the fields of education, health, and/or social services. Finally, society as a whole with its values, norms, and culture encompasses all of the systems. The experience of teenage motherhood is affected by the girl's relationship with all these systems and the interrelatedness among them.

In the model, the spiral illustrates this interrelatedness of the different systems. There is no discrete beginning or ending for each system but rather they flow into each other. Individuals are part of larger units of families and friends that are part of communities. Services go beyond local communities and society as a whole encompasses all the subsystems. Each system along with a girl's development and resources impact the experience of teenage

motherhood. The findings of this study and the existing literature will be discussed in relation to each system of influence and the core factor of relationship.

The Individual

The discussion regarding the individual is presented in three sections: (1) sexuality, contraceptive use, and pregnancy, (2) motherhood, and (3) perceived needs and internal barriers.

Sexuality, Contraceptive Use, and Pregnancy

The average age at first intercourse among participants in this study was 13.7 years old. This is significantly younger than the mean ages of 14.92, 16, 16.2 and 14.45 respectively reported for the general population of teenage girls by other researchers (Felauer, 1992; Hechtman, 1989; Hofferth, Kahn, & Baldwin, 1987; Schnirer, 1996). Some researchers have found that teen mothers become sexually active one to two years earlier than girls who have never been pregnant (Boyer & Fine, 1992; Morgan, Chapar, & Fisher, 1995). This may explain why the participants in this study had a younger age at first sexual intercourse than the general population of adolescents. However, in a study that compared sociodemographically similar teen mothers and non-mothers in Ontario, no differences between age at first sexual experience were found; both groups had become sexually active around age 15 (Oz & Fine, 1988). Therefore, the diversity of findings regarding age at first intercourse may be due to sociodemographic differences not parity. Interestingly, urban teens in this study began sexual activity earlier than rural teens (13.7 versus 14.45) who had sex earlier than suburban teens (14.45 versus 14.92). These differences may also be partly due to socioeconomic differences. Other

possible explanations for the younger age at first sexual intercourse in this study could be that teens have continued to become sexually active at younger ages in recent years, or that the sample in this study, which was small and not randomly selected, was atypical.

Another factor related to initiation of sexual activity and sexuality in general is sexual abuse. Sexual abuse negatively impacts self-esteem and can lead girls to believe their self-worth is based on their sexuality (Boyer & Fine, 1992). At least five of the participants experienced sexual abuse. Researchers have found that two-thirds to three-quarters of teen mothers had been sexually victimized (Boyer & Fine, 1992; Peterson, 1997), and that sexual abuse increases the likelihood that voluntary sexual activity would begin at younger ages (Boyer & Fine, 1992; Millar et al., 1993). The fact that at least 38% of the sample had been abused may be another factor affecting earlier sexual activity in this study. In addition, Elise (1990) found that abuse fostered physical and emotional independence. Many of the participants in this study were independent at a young age; this independence may have been partly influence by the abuse they suffered, but they also tended to come from families characterized by instability and single parenting.

Adolescents' development also influences becoming sexually active. According the Edwards (1995) teens with a weaker identify are less sure of themselves and what they believed, so they are more easily pressured into having sex. Many of the participants in this study fit her description of teens who have a weak identity. Teens with a weaker identity tend to come from troubled homes and their romantic relationships develop quickly without a strong friendship. They also initiate sex at earlier ages, sometimes have sex

with partners they barely know, have shorter relationships, and use contraception inconsistently. Participants in this study were not specifically asked why they initially became sexual active and continued to be sexually active; however, conversations revealed that some of the participants were having sex to get intimacy and love. Others had sex because their boyfriends wanted it. Some girls continued to have sex even when they did not enjoy it and were worried about becoming pregnant.

Both development and resources influence contraceptive behavior. Cognitive immaturity allowed some girls to believe "It won't happen to me". Others had ruled out an effective contraceptive option, the birth control pill, believing it "messes up your body". Sometimes they were "in the heat of the moment" and did not care or think about the consequences. Two of the participants lacked adequate information about the birth control pill, which led to improper use. Lack of communication skills, assertiveness, and substance abuse hindered consistent contraception use for others. Motivation to prevent pregnancy, which is influenced by a number of individual and environmental factors, was likely another factor that influenced contraception use. Sometimes there was no explanation for behavior. For example, participant F experienced an unplanned pregnancy at age 15 because she did not use contraception. She said she did not want to get pregnant again, yet she admitted that she and her live-in boyfriend were not using contraception. She could not explain why.

Teen mothers may need help identifying the psychosocial influences affecting their behavior and how they can deal with these influences. Perhaps participant F had not thought about how or why her behavior was inconsistent with her stated desire. On the other hand, she may actually want to get

pregnancy or be ambivalent about it but does not feel comfortable admitting that to someone. Girls who are similar to participant F may need help to examine the inconsistency between their stated desire and behavior. Girls, who use sex to meet their developmental needs, need to learn how to meet these in healthier ways. In addition to managing psychosocial issues, teenage mothers need to find a reliable and agreeable method of birth control, which is the same issue with which many older women struggle. There are obviously many interrelated factors that affect contraception use and pregnancy, and it is difficult to identify universal antecedents since factors can vary among individuals.

The average age at first pregnancy for the participants was 15.6, which is much younger than the 17.4 years reported for a sample of 224 Ontario teens (Preliminary Findings, 1997). However, similar findings were reported for samples of American teenage mothers, 15.7 and 15.9 years respectively (Boyer & Fine, 1992; Gilmore et al., 1997). The 13 participants in this study had a total of 21 pregnancies. The majority of the pregnancies were said to have been unplanned, which is consistent with the literature. Thompson et al. (1995) state that lack of knowledge and psychosocial influences lead to teen pregnancies and that first and even subsequent pregnancies are usually unplanned. Nevertheless a significant number of pregnancies appear to be planned. Twenty-three percent of first pregnancies in Boyer & Fine's (1992) sample and 44% of second pregnancies in East & Felice's (1996) sample were planned; however, only three of the pregnancies in this study (14%) were said to be planned. A surprising finding in this study was that many of the teen mothers had a romanticized notion of pregnancy and parenthood despite

having experienced the reality at least once. A number of girls said they enjoyed their pregnancies, missed being pregnant, and could not wait to get pregnant again. When they were around infants, they said things like "Oh, I want another one". These types of feelings or attitudes may affect the girls' motivation to use contraception whether consciously or subconsciouly.

Sometimes repeat pregnancies are unplanned but they are not necessarily unwanted. Participant G got pregnant again although she claimed to always use contraception. She was shocked at the pregnancy but happy. Part of the reason repeat pregnancies occur is because the factors that led to the first pregnancy were never addressed. Many of the interventions to reduce repeat pregnancies focus on contraception knowledge and access, which Maynard & Rangarajan (1994) found to have little effect on rates of repeat pregnancy. Teens need more than knowledge and access to contraception; they also need to be motivated to delay subsequent pregnancies. However, we have to also realize that teen mothers, like older mothers, sometimes plan subsequent pregnancies because they want to complete their family and/or do not want their children to be spaced too far apart.

Motherhood

Participants' went through a mix of reactions when they found out they were pregnant. They were shocked, scared, happy, and excited. Although most participants said they did not intend to get pregnant, once they found out they were pregnant it did not take long before they were happy about the pregnancy and wanted the baby. Perry & Grew (1993) had similar findings with pregnant adolescents in rural Nova Scotia. During the first interview, pregnant participants reported feeling scared and disappointed, but four weeks later at

the second interview they were mostly happy and excited. Other researchers have also found that "unplanned" pregnancies lead to welcomed and wanted babies (Furstenberg, 1991; Irvine, Bradley, Cupples, & Boohan, 1997; SmithBattle, 1995). This raises the question, why are some teen girls happy to become mothers? Obviously, these girls do not view teenage parenting as a catastrophe.

The participants chose motherhood over other options and did not regret it; they enjoyed being mothers, and they found motherhood exciting and rewarding but at the same time tiring and time-consuming. Other researchers have also found that adolescent girls perceive motherhood as a positive experience. In a five-year follow-up of teenage mothers who were enrolled in Project Redirection, Polit (1989) found that being a mother was an important and rewarding part of their lives and that few regretted it. The maternal role was also found to be rewarding yet difficult for adolescents in Thompson et al.'s (1995) study.

The experience of motherhood influenced teens' identity development. Motherhood became an important part of participants' self-identity. The participants saw themselves as normal mothers not "teen mothers". They felt age had little impact on parenting—first-time mothers, whether 15 years old or 35 years old, were the same—they were learning as they proceeded. Although they were chronologically teenagers, many of participants felt older and more mature than other teens. Some participants' self-identity seemed to be more wrapped up in motherhood than others. Participant A was not in school and her world revolved around her children. Her primary identity was as a mother. Participant G was enrolled in school, but she did her studies at home. She

seemed to perceive herself as a mother who happened to be going to school. She said that she did not even remember what it was like not to have children. For some of the other girls motherhood was secondary to their identity as a teen. Motherhood served an important function for many of the adolescent girls. Similarly, Arenson (1994) reported that children made teen girls feel better about themselves and gave them a more concrete role and positive identity.

The participants' developmental level also influenced how they viewed motherhood. A 19-year-old participant described motherhood as being a wonderful experience, having a child brought much light and joy to her life. The best thing was looking at her child and knowing she created her and that the child was her responsibility. In contrast, a 16-year-old participant described motherhood as always having someone to talk to, take around, and show off. These two descriptions portray very different developmental levels. Although developmental differences can usually be seen among teens who differ in age, age alone is not a good predictor of development level. Flanagan et al. (1995) found the developmental complexity of mothers' responses to self-related questions to be similar to their responses to motherhood-related questions. As adolescents grew developmentally, they also grew in their understanding of motherhood.

Overall, the participants had very positive maternal identities and believed they were good mothers. They felt they were good mothers because they provided for their children's basic needs (food, shelter, and clothing), gave their children love and attention, and put their children's needs first. Hardy (1993) and Phoenix (1991) also found that adolescent mothers viewed

themselves positively and felt they were good mothers. I spent enough time with some of the young mothers to see an array of positive behaviors as well as some behaviors that may not be as desirable. For example, profanity was sometimes used in front of children and some girls used terms of endearment that may be considered inappropriate such as "booger". Teens are often judged to be bad parents based on instances such as these or on things such as a messy house. We have to refrain from judging these girls against middle-class standards when this is not the environment they experience growing up. The behaviors and interactions judged to be "bad" by outsiders may be considered "normal" by these girls and their families. Negative patterns of relating and parenting that participants were exposed to while growing up often became part of their parenting unless they found more positive examples and role models. Delay childbearing until they were older would not necessarily reduce these "negative patterns" because parenting is influenced by experiences not just age.

The teen girls made many positive changes in their lives after having a child. A number of the participants talked about partying, drinking, doing drugs, and skipping school prior to becoming pregnant. Having a child made them "grow up", mature, become more responsible, and motivated them to complete school. The teen mothers changed their lifestyles; they left the party scene and tried to create a good life for their children. A teen mother interviewed for a recent newspaper article in Edmonton said getting pregnant "straightened her out" (Bow, 1998). Teen mothers interviewed at Terra school in Edmonton by Hardy (1993) also reported that having children motivated them to attain their goals. Arenson (1994) and Marshall (1994) both

discovered that becoming a parent led to positive changes for adolescent girls including decreased alcohol and drug use, gang involvement, family violence, and conflict with their mothers along with increased self-esteem, self-worth, pursuit of educational goals, and access of professionals.

Participants talked mostly about the positive effects of having a child whereas the literature focuses on negative consequences. Why such a difference? Some people may believe that teenage mothers see only the present and are unable to see the long-term consequences. However, immediate needs such as having someone to love, having a sense of purpose, being in control, and being independent need to be met before the future can have any significance to these women. Moreover, the positive short-term changes teen mothers reported such as leaving the party scene and returning to school will lead to positive long-term consequences. Some girls may actually have had bleaker futures if they had not become a parent.

Teen mothers are fully aware of society's negative attitude and prejudices against them, but they rebut these stereotypes. Participants argued that age had little to do with their ability to be a good mother; they are just as good mothers as older women and sometimes even better. They even identify a number of reasons why parenting at a young age is better. This may be a belief they held before getting pregnant (and if so it may have influenced their pregnancy status); on the other hand, it could be their way of justifying being a teen parent. Teen mothers in Hardy's Edmonton study also reported their youth as an advantage. Horowitz (1995) and Phoenix (1991) state that this is a strategy teen mothers use to justify and rationalize their situation.

Perceived Needs and Internal Barriers

Teen mothers' subjective perceptions are more important than "objective reality". Their reactions, decisions, and behaviors are based on how they experience the world. It does not matter what everyone else thinks teen mothers need, unless teen mothers also perceive a need they will not be motivated to do anything about it. Furthermore, just because professionals design a program to meet a need identified by teen mothers does not mean that the teen mothers will use the service. There may be a number of barriers and perceptions that have to be overcome first.

In this study, the problems and concerns of the participants can be summed up in one word "stress" and their needs come down to one factor "support". During their pregnancy, participants worried about the baby's health, labour, and whether they would be good mothers. Some girls were stressed by their relationship with the putative father and their family, which is similar to findings of other researchers (Panzarine, 1986; Perry & Grew, 1993). Although relationships were sometimes stressful, the girls feared being alone. According to Robinson (1993) social isolation can be a significant source of stress. This may be one reason why many participants entered relationships very quickly and when their relationship ended they went immediately into another one. One of the biggest stressors for participants in this study and in other studies was finances (Perry & Grew, 1993; Polit, 1989; Schlesinger, 1985). Poor financial circumstances caused stress because most girls were on a fixed budget, and they often ran out of money for basic necessities and had little spending money for leisure activities. As well, participants were either dependent on others, which striped them of control and autonomy, or they had

to deal with agencies such as Social Services or Student Finance, which was often unpleasant and difficult.

Many of the participants were unable or unwilling to identify needs when asked directly. Their response was often **"Oh, I don't really need anything right now."** However, as specific topics came up such as childcare, finances, and services, participants mentioned various concerns and needs. Participants acknowledged the importance of and need for various types of support. Practical support (e.g. money, help with household chores, and childcare), affirmational support (e.g. being told they are good mothers), emotional support (e.g. sharing and being understood), and informational support (e.g. knowledge about community services and child rearing) were all identified as important to participants. Teen mothers try to give an air of confidence; however, they need reassurance that they are doing a good job as mothers (Mitchell, 1996). Sometimes needs were globalized. The participants would say, **"There needs to be more support for teen moms, but I didn't really need any. I was told I was a natural born mom."** The teen mothers seemed to appraise their parenting resources (knowledge and skills) as above average. Mothering was also viewed as natural and something that you learned as you went: **"No one can tell you how to do it right."** Similarly, participants in Perry & Grew's (1993) study saw themselves as well informed and having a great deal of experience with babies.

The teen mothers in this study did not always use available services and were not always happy with people's attempts to help. A number of factors influenced their use of "supports" and services. First, as mentioned above, participants had to perceive a present need. A future need did not provide

sufficient motivation. Often these girls had so many demands in the present that future needs were not a priority; they took life day by day. As long as they know what they need to know at that time, seeking more information is not a priority. Another factor holding participants back from asking for or accepting help was the need to do things by themselves. This desire for autonomy and independence is natural in adolescence, but it can come into conflict with the teen mother's need for support. In addition, many of these girls' life experiences taught them to care for themselves because they could not rely on anyone else to do so.

Help or support was not always perceived positively. The actions of both family and professionals often made teens feel less confident and competent as a mother. Unsolicited and unwanted advice, comments, suggestions, and demonstrations on how to do something were often perceived as a criticism or judgement of their abilities. The teen mothers were intimidated by professionals such as doctors and social workers and found it difficult to ask questions or voice their concerns. They were not persistent when their questions were not answered to their satisfaction, and they were not assertive of their rights and needs. Perry & Grew (1993) report that not feeling comfortable asking for help was the most common barrier to receiving help. A number of participants mentioned being turned off some services by bad reports, experiences, or feelings. Teens' first impressions of staff at agencies and the practitioners' ability to quickly develop rapport were important factors.

The teen mothers looked at the pros and cons of using services or seeking help, and if there were many cons they did not bother. For example, participant C was invited to attend a parenting group on a number of

occasions. First of all, she did not perceive a high need for such a group. It was not that she believe she did not need parenting skills, but she felt she could get the information she needed from her family and books. Plus, participant C said she knew whom to call if she had questions or concerns. Her time was limited and she preferred to spend it with her friends or her daughter. Furthermore, she could not relate to the other girls who had family problems and financial difficulties.

Teen mothers are affected by many personal factors and these factors are all interrelated and have a combined, cumulative effect on the individual. Girls' development, resources, and behavior are also impacted by many variables external to the individual. It is virtually impossible to identify all of the variables affecting an individual never mind untangle their effects. The relationships between the individual teen mother and other systems that influence her are now explored and the impact they have on the experience of teenage motherhood is examined.

Family & Friends

The most immediate outside influences on teen mothers were their family, the baby's father, and their friends. The way they experienced the world was fundamentally influenced by the context they grew up in and how they coped with their present situation was mediated by their relationships with these individuals.

Context

While complexity and change described the general pattern of the participants' lives, it was not an accurate description of all the girls' individual situations. Pregnant and parenting teen girls are not a homogenous group and

neither was the sample in this study as two of the participants came from intact stable families. Most of the participants, however, had chaotic lives. Their parents divorced when they were young or their mothers had never married. Many of them lived in a number of different situations over the years including living with both parents, their mother, their father, blended families, relatives, friends, or boyfriends. Some participants also had to manage with numerous family problems such as alcoholism, mental illness, depression, neglect, abuse, and financial difficulty. This type of background has been commonly reported for teen mothers (Arenson, 1994; Biddle, 1995; SmithBattle, 1995). The teen mothers in this study were also independent at a young age. Some girls left home in their early teens and lived with boyfriends or relatives. Others were still at home but had little parental supervision or had parent(s) who gave them a lot of independence and freedom. Black & DeBlassie (1985) and Biddle (1995) also noted that teen mothers had been emancipated from their parents earlier than most teens.

"There is strong evidence that early childhood experiences influence coping skills, resistance to health problems, and overall health and well-being for the rest of one's life" (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996, p. 74). Participants' childhood experiences interacted with their individual characteristics such as traits and capacities to shape them into the young women they were. The environment they grew up in no doubt affected their values, beliefs, attitudes, thoughts, and actions. It is obvious by some of the participants' quotes that they did not have positive role models growing up. Participant E referred to her mother as **"a fat sow...very mean and very selfish"** and participant G said her father was **"manipulative".**

Some participants came from families where they never experienced positive parenting skills. Biddle (1995) found that the lack of a positive parental role model meant the girls do not learn positive skills. She spent a fair amount of time with one of her participants and her children modeling positive interactions. One day the mother said to Biddle, "I can't talk to my kids the way you do. Can you help me [learn how]?" This comment demonstrates how important modeling is; too often teen mothers lack positive role models and begin to parent the way they were parented. On the other hand, Arenson (1994) reports that a number of teen mothers try very hard to be a better parent than their parents.

Parenting is only one factor affected by participants' family context. Growing up in single-parent homes may have created more favorable attitudes towards single parenting. Premarital sexual intercourse and common-law living arrangements were modeled in some of the participants' homes, which likely affected their values regarding sex and marriage. Furthermore, girls' emotional and social development along with their self-esteem were affected by the relationships and experiences they had. In some cases, participants did not have their basic needs for food, shelter, safety, love, and belongingness met. Poor relationships with parents or the absence of a father likely had a negative effect on girls' development and self-esteem.

Some participants were living at home when they got pregnant, others were on their own; however, all girls told their parent(s) of the pregnancy. Two of the participants' mothers and one father were happy about the pregnancy. Why would a mother/father be happy and excited that her/his teenage daughter is pregnant? Apparently, in some families teen pregnancy is not

viewed as a crisis but rather as an acceptable situation. Little was found in the literature about specific family members' reactions to teen pregnancy, but it was noted that some cultures and socioeconomic groups might have more favorable attitudes towards teenage childbearing (Furstenberg, 1991; Jorgensen, 1993). Most families did not appear to have a direct influence on the participants' pregnancy decision, even though some parents pushed adoption or abortion, the girls still decided to have and keep their child. Only participant D's relatives seemed to have influenced her decision. However, the families indirectly influenced participants through implicit values and norms.

Teenage pregnancy appears to be generational and cyclical (Clarke, 1987). Girls whose mothers, sisters, or other relatives were teen parents are at higher risk for becoming teen parents themselves (Steven-Simon & McAnarney, 1996). It is known that some of the participants' mothers were themselves teen mothers. The familial nature of teen pregnancy can be seen in participant G's family. Her mother had her first child when she was 16 years old, married the baby's father, and then went on to have four more children. Participant G was the third child. She had two older sisters (Rachel and Sara[17] respectively) and a younger brother and sister. One day Sara, who was 14 years old, said she had to go to the hospital; she was in labour. She had hidden the pregnancy. Participant G's mother raised the baby along with her five children. Five months later, Rachel, who was 16 years old, had a baby and the grandmother cared for this baby as well. Two years later, Rachel had a second child. Eventually, Rachel and Sara moved out on their own with their children. A year after Rachel had her second child, participant G, who was 15 years old, found

[17] Pseudonyms

out she was pregnant. She had her baby but raised the baby by herself. When participant G's baby was around 10 months old, she found out she was pregnant again. Now she has a toddler and an infant. Why is teen pregnancy so prevalent in some families? Is it because there is an accepting attitude towards early parenting? Role modeling? Family dysfunction? The youngest girl in this family is just entering her teens. Will she experience the same fate as her mother and sisters?

Family Support

The support that participants received from their family during pregnancy and parenting depended on the quality of their relationships prior to becoming pregnant. As described above, many of the participants came from unstable families. Six of the participants were not living with their parents when they got pregnant. Four of these girls continue to received some support from their parents; however, participants F and M had little contact with their families. The seven participants who lived with their parent(s) were being supported financially. During their pregnancy, participants received informational and emotional support from their families especially their mother, sisters, and aunts. Most girls had family members present during labour and delivery, and after the birth most families provided practical and informational support by helping with the newborn. An important factor affecting the amount of support from family was where participants lived. Obviously, if the girl lived with her parents, there was more opportunity for daily support whether in the form of aid, information, or emotional support.

In the literature, teenage mothers consistently report their mother as one of their most important sources of support (Arenson, 1994; MacBean,

1994; May, 1992; Panzarine, 1986; Perry & Grew, 1993; Robinson, 1993; White, 1990). Findings from this study suggest that the mother only plays a key support role if the teen girl has a good relationship with her. The majority of participants did not have substantial support from their mother due to estrangement, conflicted relationships, or distance. Participants with limited support from their mother relied on other family members such as fathers, stepmothers, sisters, aunts, and grandparents. Two participants who had little or no family support had the help of a foster family for a time.

Social support networks can be characterized by their source of support, size, frequency of contact, duration of relationship, and recent loss (May, 1992). These network variables can change; therefore support is not constant, it fluctuates over time. During the postpartum period, there tended to be an abundance of family support plus support from friends and professionals. It was an exciting time and many people visited and assisted. Participants in Perry & Grew's (1993) study said that there were too many visitors initially. This has been labeled the "honeymoon period" (Burke & Liston, 1994). The length of the honeymoon period can vary depending on family resources. Furthermore, if all family members were working, there was less time available for extra support. Participants who lived on their own received less daily support than girls who lived with families. A hospital social worker found that many teen mothers were confident when they left the hospital—they believed they had lots of support; then about a month postpartum, they would call her in crisis (L. Butler, personal communication, June 23, 1998). The mothers did not think that newborns would be so much work ("I thought they were

supposed to sleep all day.") and their supports had either diminished over time or were not as helpful as anticipated.

Levels of family support continued to change over time. Participant G lost her mother as a support when her mother moved to another province and had to compensate with other family members. Participant F had no family so she lived with a foster family, but when she moved out on her own she essentially lost this support. Although the majority of teen mothers live with parents or relatives after the birth of their baby, this is usually a transitory stage (Furstenberg, 1991). As time passes the number of teen mothers living with family sharply decreases. Nine of the eleven teen parents were living with a family (parents, relatives, or foster family) postpartum compared to only two teen parents by the end of this study. Other studies have found that moving out on one's own reduces family support considerably, mostly due to decreased frequency of contact (Jorgensen, 1993).

Support networks have supportive and stressful elements. The teenage mother's mother is an important source of support, but at the same time she is one of the main sources of tension (Burke & Liston, 1994). There were occasional role conflicts between participants and their mothers especially when they lived together (which may be why many teen mothers are anxious to live independently). Participants were upset when grandmothers acted more like mothers. They felt their mother was doing their job. SmithBattle (1995) also found that grandparents often subverted the teenage mother's relationship with her infant. "Helping" from grandmothers and other relatives was often seen as questioning the teen mothers' abilities and undermining their autonomy and self-esteem. Intergenerational parenting is complex,

conflict-ridden, unstable and has mixed results (Furstenberg, 1991). One problem could be that when the baby comes home, all the family's attention is on the baby. At this time, support is likely focused on practical aspects of childcare. However, teen mothers in this study and other studies (May, 1992; Perry & Grew, 1993) have identified emotional support as their greatest need during this time. Teen mothers need for others to "mother the mother" not "mother the baby". Participant B said she looked after her baby all day but she had no one to take care of her and her needs. This is important because "mothers who felt cared about, loved and supported in their behavior were able to provide more sensitive and nurturant maternal behavior" (White, 1990, p.60).

Social support is an important factor that lessens the impact of stress on health and functioning, plus social support network members have the greatest influence on health behaviors (Stewart, 1995). Unfortunately, not all family effects are positive. Participant E's mother provided some informational and practical support, but at the same time she was verbally abusive. It also appears that some families provided prenatal information to participants rather than encouraging them to attend prenatal classes. Family dysfunctions present before the participant's pregnancy were still there following. Relationships that were conflicted continued to be conflicted. These negative aspects of relationships have not been well investigated (Stewart, 1995); perhaps some teen mothers should not rely on family support because of unhealthy family relationships.

Putative Fathers and Boyfriends

Only a few questions were asked specifically about the fathers of the participants' children: (1) their age, (2) their reaction to the pregnancy, and (3)

their involvement with the child. Other information was revealed while participants were telling their story or during informal conversations. The fathers' ages ranged from one year younger to nine years older than the participants with an average of 3.6 years seniority. In a review of Canadian vital statistics, Millar & Wadhera (1997) found that 77% of births to teenage mothers were fathered by men who were older. The average difference in age was 4.1 years. Among mothers aged 15 to 19, 26% of fathers were six or more years older. In this study, 8 of 21[18] pregnancies involved men who were six or more years older than the participant. Why are older men fathering so many of the children to teenager girls? Millar & Wadhera (1997) wonder whether these relationships are sexual exploitation or abuse. Only one participant in this study indicated that a relationship was abusive. I suspect that girls "hook up" with older men when they are dropped out of (or are skipping) school. These men tend to have a low education level (Taylor, Chavez, Chabra, & Boggess, 1997) and perhaps they feel more comfortable with younger girls. On the other hand, they may just be taking advantage of young girls who are looking for love and affection.

Pregnancy generally occurs due to ineffective or inconsistent contraption use; however, the role that males play in contraception use is too often ignored. Edwards (1995) found that if partners were not supportive of using contraception girls usually did not push the issue. Men too often discourage the use of condoms, and they are willing to have sex without contraception. IT appears that they think pregnancy is not their concern. Moreover, some men

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[18] One participant had 5 of the pregnancies, so 4 of the 13 girls had a pregnancy by a man six or more years older than themselves.

actually encourage their girlfriends to get pregnant; two girls in this study and one in the Edwards' (1995) study reported their boyfriends encouraging them to get pregnant. One would think that older men would be more responsible when it came to contraception; however, Taylor et al., (1997) report that adult-teen relationships have a higher rate of pregnancy than teen-teen relationships. Thus, older men are likely using condoms less than teenage boys and/or these older men do not encourage or support teenage girlfriends to use contraception. Obviously, interventions need to target teenage boys and older men if they are going to have success at preventing teenage pregnancy.

Some of the participants indicated they had not been in the relationship long before getting pregnant, and from conversations with other girls it sounds as if this was the norm not the exception. This is a change from research in the 1980's that reported teenage mothers had known the father for over a year (Black & DeBlassie, 1985; Macdonnell, 1981). More recently, Fillon (1996) and Stodghill (1998) report that teens are having sex in more casual relationships; therefore, it is not surprising that pregnancy is also occurring in casual relationships.

A few participants discussed their suspicions with their boyfriend but most told their boyfriend after they had confirmed the pregnancy. In any case, the baby's father was usually the first person with whom the participant talked in this study, and this finding is supported by Perry & Grew (1993). The fathers-to-be responded with a mix of emotions such as disbelief, anger, or happiness. Participants in this study discussed the pregnancy decision with their partner, but it is difficult to know what influence the partner had on the decision. Often

the decision to keep the baby was made thinking that the baby's father would be available and supportive; however, the majority of the participants' relationships ended before they gave birth. Why do so many boys/men not take responsibility when they father a child? On two occasions during coffee with the mothers from the support group, we chatted with young men who had children. Both times the men bragged and boosted about having children, yet neither of them had much contact with their children. One man was 17 years old and had already fathered two children with two different women.

Both McBean (1994) and White (1990) report the father of the baby (or male partner) to be an important support person; however, over half of the participants in this study were not with the baby's father. The father seemed to only stay involved with the child if he was also dating the mother. If the relationship ended the fathers usually had nothing to do with the child and did not provide any financial assistance. One boyfriend said, "I'd rather be a full-time dad or no dad at all." Even a father, who had parented his children for 2-3 years, ended all his involvement with them when the marriage ended. Four fathers were involved with their children, but their involvement was inconsistent. Furstenberg (1991) states that teen mother's relationships with the fathers of their children are highly unstable and that few fathers see their children regularly or give any financial support. On the contrary, Perry & Grew (1993) found that the majority of fathers were providing financial support and were involved with all aspects of childcare. Perhaps this is an urban/rural difference. Teens from rural communities may have had a more serious relationship with the father prior to the pregnancy. Plus, in a small community

everyone seems to know everyone's business, and it may be more difficult for a father not to take responsibility for his child.

An interesting finding in this study was that two men were stay-at-home dads even though one of them was not the biological father. Participant K lived with her child's father on a reserve, and the father looked after the child while the mother went to school. He had never finished high school and did not work. Participant F moved in with a boyfriend when her baby was 8 months old and he cared for the baby and the household. He was also a school dropout and did not have a job. I wonder what motivated these two men to be full-time caregivers. Do they genuinely enjoy this and have the best interests of the child in mind or do they think it is easier to live off their girlfriends and baby-sit a child than find paid work? Participant G's boyfriend also took on the paternal role although more selectively. He was happy to play with her child, but he did not want any responsibility. Even though he worked at a good job and practically lived at the participant's house, he rarely helped out financially. Similarly, he fathered a child with her, he took no responsibility, and had almost no involvement with his baby.

Relationships with the baby's father were an important influence in the participants' lives. The characteristics of the relationship likely affected the boyfriend's reaction to the news and how much influence he had on the participant's pregnancy decision. The strength of the relationship influenced whether they stayed together or whether the relationship fell apart. Unfortunately, many of the relationships were not mature relationships and they did not last under the strain of an unplanned pregnancy. It appears that the presence of the baby's father was often more of a stessor than a support.

The on and off nature of the relationships and conflicts over visitation, support, parenting, and behavior such as drug use was stressful for the teen mothers. An additional source of stress was that the father did not take as much interest and responsibility in the child's life as expected or desired. Over half of the fathers took no responsibility and had nothing to do with the mother or child. The others were "daddies" when it suited them. They were not "parents" but visitors or babysitters; most had little involvement in the day-to-day childcare and did not take any financial responsibility. The teenage mother bore all the responsibility for a child that it took two to create. The father too often abdicated his responsibility and went on with his life as if nothing happened.

Friends

As adolescents try to develop independence from their family, peers become more significant (Lefrançois, 1989). Peers may be more important to teens who come from broken, unstable homes, similar to the participants in this study, because they have less support from family and have more autonomy at a younger age. Munro, who has been investigating the risk-taking behavior of adolescents, says that kids who have bad relationships with their parents "build their own support system because they don't get the support at home" (cited in Armstrong, 1998). Friends appear to influence sexual practices and pregnancy risk. Steven-Simons & McAnarney (1996) state that teens who have many friends who are teen parents are at greater risk for pregnancy. The participants in this study all had friends who were teen mothers; however, it is not known how many of these friendships developed after becoming mothers and how many were friends before becoming pregnant. However, Participant F

mentioned that even before she was pregnant many of her friends had children.

Friends may have some influence on pregnancy-risk, but they are also a significant source of support for teen mothers. The participants valued friends who were also teen parents because they were empathetic and gave useful suggestions. Young mothers were a source of informational, emotional, and practical support. Three participants met at the support group, became friends, and shared and listened to each other's trials and jubilations. They swapped babysitting, went out socially, and shared resources such as baby clothes, books, and equipment. Although they phoned and saw each other outside the support group, the support group remained an integral element holding them together. It was a stable force that brought them together every week that they did not have to initiate or plan—a location was provided along with snacks and a variety of activities and occasionally childcare. The group was also held in the early afternoon, and the girls who were in school obtained permission to miss school to attend; therefore, the group was not an additional time burden. The busyness of their lives and lack of resources seemed to be barriers to sustaining regular contact on their own. The regular contact at the group provided opportunities for them to plan get togethers outside the group.

Peer support is an effective intervention for many populations (Stewart, 1995) including teen mothers (Robinson, 1993). Dunham, Hurshman, Litwin, Gusella, & Ellsworth (1998) studied the use of a computer-mediated social support network for young single mothers in Halifax. Participants in their study were provided with computers that they could use to access a bulletin board where they could post messages to a public forum, send private email, or

do real-time text-based conferencing with up to eight other participants. Dunham and his associates found that teen mothers who were socially isolated or had young infants were more likely to use the computer network. Participants experienced a greater sense of community and less stress the more they accessed the system. The majority of posted messages focused on the mother especially her mental health; 56% of replies provide emotional support and 37% provided informational support. Many of the young mothers developed close personal relationships and had some contact outside the computer network.

The findings from the Dunham et al. (1998) study support the finding from this study. Peer support is highly valued by teen mothers; it is an important source of emotional and informational support and it appears to decrease stress and help with coping. Dunham et al. (1998) reported that 55% of their participants accessed peer support on a consistent basis as compared to a 10-20% rate reported for other services. The most frequently used service in this study was also peer support groups. According to the literature and findings from this study, there are a number of reasons why peer support is preferred over professional support: (1) teen mothers feel more comfortable with and can relate better to peers, (2) relationships are reciprocal; they give and receive support, (3) relationships are more than support; they are companionship and friendship—they are personal not distant, (4) peers are more accessible than professionals, (5) the focus is on what is important and relevant, and (6) their social needs take priority over other needs.

Community

Teen mothers grow up in families, and families function within communities. Just as there is great variation in families, there is also great variation among communities. Communities can vary in age composition, income levels, health status, crime rates, available resources, and a multitude of other factors. Figures presented in the Capital Health Region Health Status report illustrate the disparities between two communities (Capital Health, 1996).

Table 4 Community differences

Indicators	Central[a]	St. Albert[b]
Low income families	32.5%	6%
Population with < grade 9 education	17.8%	2.7%
Families headed by single parents	21%	10%
Babies born at low birth rate	8%	3.1%
Teen birth rate (girls aged 15-19)	73.3/1,000	6.9/1,000

[a] Community in Central Edmonton that includes the inner city, population 55,209.

[b] Suburban community adjacent to City of Edmonton, population 44,195.

As illustrated by the figures above, low socioeconomic families tend to be concentrated in certain communities. It is likely that the values and norms between communities such as these differ. Obviously, the differences between these communities affect the context within which teen girls and their families are living.

The majority of participants in this study lived in lower socioeconomic areas of the Capital Health Region. Some of the participants grew up in these neighborhoods, others moved to them to find low income housing. The population in these areas tends to be more unstable and transient than higher income areas where most families own their houses. Lower income areas may be less connected communities. For example, participant B said that it would

be nice to have neighbors who could help each other out. She commented that in the community she was in, she did not want to know her neighbors let alone invite them into her house; she said her neighbors were drug dealers. Participant A also talked about the neighborhood being unsafe. She was fearful walking home after work at two or three o'clock in the morning, but she did not have any choice; she could not afford to take a cab home every night. When searching for subsidized housing, one participant had the opportunity to move in next door to one of the other participants. Although it would have been helpful to have a friend next door, she chose not to because she felt the neighborhood was too unsafe. In White's (1990) study of social support, only 2 of 30 participants identified neighbors as members of their support network. In addition, lack of transportation meant that teen mothers in this study did not have many opportunities to get out of their communities. Therefore, they are dependent on the resources and services available in their neighborhood. The types of neighborhoods teen mothers were forced to live in influenced their social support networks and their level of stress.

As Furstenburg, Brooks-Gunn, & Morgan (1987) point out:

> Economic resources determine much of the variability in a child's environment. For example, children who are reared in poverty are more likely to live in unsafe neighborhoods, to attend poor-quality schools and to associate with peers who do not value education or the delay of sexual activity. (p. 149)

Teen mothers were more likely to have grown up in low socioeconomic neighborhoods themselves, and the cycle seems to continues for their children also growing up in neighborhoods plagued by poverty. Efforts to address teen pregnancy need to come from policy makers and local communities to address

the factors that "shape the views of children and youth" (Furstenberg, 1991, p. 36).

Services

Services are another level of influence on teen mothers, and they impact teen mothers in a number of ways. Pregnant and parenting teens are affected by what services are and are not available to them. They are affected by whether they chose to access a service and by service regulations and policies. Furthermore, service providers influence teen mothers' use of and experience with services. Relationship is one of the most influential factors between individuals and services.

In this study participants were involved with a number of services encompassing health, social services, and education. The first service the participants accessed after they suspected they were pregnant was usually a medical clinic. All the girls had their pregnancy confirmed by a doctor and the majority began prenatal visits during their first trimester. Similarly, researchers for a teen prenatal study in Ontario reported that 85% of teen girls saw a doctor during the first trimester. However, in Perry & Grew's (1993) study less than half of the girls visited the doctor in the first trimester.

Only three participants in this study attended prenatal classes versus almost three-quarters of older low-income women in Sword's Ontario (1997) study. Teen girls in Sundby's (1995) study reported not feeling any more prepared after taking prenatal class, yet participants in this study, most of whom did not take any prenatal classes, stated they felt adequately prepared. Sundby (1995) also states that girls wanted more information and practice on breathing techniques, but in this study breathing techniques were what girls

hated the most in classes. Others did not take classes because they believed they already knew how to breathe and focus. Further differences were seen in labour and delivery experiences. According to girls in Perry & Grew's (1993) study, the nurses and physicians were all very helpful. Nurses acted as coaches, provided information, listened, and gave positive feedback. However, participants in this study reported more negative experiences than positive ones. Similarly, girls in Sundby's (1995) study also reported feeling intimidated by the nurses.

Besides health-related services, teen mothers also used a variety of social services such as social assistance, child welfare, subsidized housing, subsidized childcare, and student finance. Five participants had used social assistance at some point while nine had received student finance. There is little choice or flexibility since these are government provided or regulated services. Overall, participants found these services difficult to use; their rules and regulations were inflexible and workers were often unpleasant and not very helpful. There was also an element of fear in dealing with some of these systems such as child welfare.

In addition to health and social services, participants were involved in educational services although sporadically. A 1991 Statistics Canada survey reported that 1 in 4 students drop out at some point during their school career (cited in Bibby & Posterski, 1992). All participants in this study had dropped out at some point. Drummond & Hansford (1992) state that pregnancy is the most common reason for drop out; however, two-thirds of the pregnancies in this study occurred after or during the process of dropping out. Similarly, two-thirds of Oz & Fine's (1988) sample had dropped out prior to becoming

pregnant. Obviously, pregnancy is not the only or even the most salient factor in school drop out. School drop out was affected by a number of variables including family problems, frequent moving, stress, difficulty with teachers, demands of work, poor achievement, authority problems, and sometimes pregnancy. Some participants in this study indicated they were below average in school, but just as many were doing average or above average which is support by Bibby & Posterski (1993) and Weber (1991). For participants in this study dropping out was most often the end result of skipping classes to hang out with friends and subsequently getting caught up in the party scene. The combination of increased freedom in high school and lack of parental supervision and monitoring allowed the girls to get to the point of dropping out. In another study, teens themselves identified lack of parental supervision as a risk factor for dropping out (Britt, 1995).

Participants in this study who were in traditional school environments when they became pregnant found many of the teachers unsupportive and the administration inflexible. One girl reported that her principal suggested that she leave school until after she had her baby. Other researchers have also found the school environment to be unsupportive towards pregnant and parenting students (Biddle, 1995; Nash & Dunkle, 1989; Thompson et al, 1995). Teen mothers do not function well within a traditional school and prefer an alternative school setting (Kopacsi, 1990; Weber, 1992). Participants in this study chose eventually to attend an alternative school because they found the environment more flexible and comfortable. For example, one girl liked a special school for pregnant and parenting teens because it had a flexible

schedule, was self-paced, and individualized. However, when it changed and became more like a regular school she left.

As discussed previously, participants in this study did not always use services—often because they did not perceive a need for them. However, another reason is that they frequently were not aware of available services. Sword (1998) states that the primary issue in service use is being informed about programs. Teen mothers in this study all had contact with a doctor and many with a social worker or child welfare worker; unfortunately, these professionals usually did not refer girls to other services or even provide them with information on services. When teens tried to find or access services they were often discouraged. Sometimes they were given inaccurate information, told to try a different agency, or told they did not qualify for the service or program. The problems of locating services were further exacerbated because participants did not ask the right questions, know their rights, or persist until they found services to meet their needs.

The entire process of finding and using services, especially government services, was frustrating and stressful. As documented in previous literature, the key to the use and success of any service (after finding it) was always rapport and relationship as has been found by many other studies (Adams & Kolic, 1997, Armstrong, 1998; Jorgensen, 1993; Marsh & Wirick, 1991; Sword, 1997; Yoos, 1987). Staff needed to be able to engage the teen mother and establish trust. To do this, they had to be warm & caring, non-judgmental, sensitive to individual needs, and able to connect interpersonally. In order to develop a relationship, contact with the same professional over time is needed.

This is likely why case management has been reported to have positive results (Frager, 1991b; Opuni, Smith, Arvey, & Solomon, 1994; Warrick et al., 1993).

Services are supposed to help teen mothers, but many services, especially government ones, involve complicated processes and a number of policies and regulations that constrain and even negatively impact teen mothers. Managing the bureaucracy and paperwork is often stressful and overwhelming for a teen mother. For example, one girl needed a paper signed by Social Service verifying her support in order to secure a subsidized apartment. It was Wednesday and she needed this by Friday so that she could move in on Monday. A Social Service employee told her it would take at least a week to get the paper signed. Luckily, she found someone to advocate for her and got the matter resolved. Daycare policies also negatively impact teen mothers. Teen mothers with low-income can get subsidized daycare but only if they put their child in care full-time which is not appropriate for a mother who only needs part-time care. This policy also encourages mothers to leave their child in daycare longer than necessary to obtain the required number of hours for a subsidy. Consequently, this policy does not promote effective parenting or mother-child interactions.

The Health for two program, student finance, and school board policies also hinder effective parenting and set up some teen mothers for hardship or even failure. Teen girls are given only four weeks maternity leave from school, after which they must return or lose their funding. Teen mothers find it difficult to return to full-time studies and care for a newborn; many of them ended up doing poorly in school or dropping out. Furthermore, if they return to school, they cannot breastfeed. Formula feeding is expensive and not as

healthy, but short maternity leaves and few schools with daycares or flexible scheduling provide limited choice. In addition, while breastfeeding moms qualified for milk coupons, if they changed to formula feeding not only did they have the added expense but they also lost the milk coupons. Moreover, public school attendance policies only allowed teens to attend their community high schools for three years, and if they want to continue schooling after this they have to go to a central high school. This causes even more problems for teen mothers struggling to stay in school. The hassles created by services compound the daily hassles, worries, and concern that teen mothers experience.

According to the literature and the findings from this study, there are five important factors related to providing services to teenagers. One, first impressions and experiences are crucial. A bad experience will deter teens from returning. Two, staff must have a positive attitude and effective people skills. Three, taking time with teenage clients is important. It takes time to establish rapport and spending time with them and listening to them demonstrates you care. It can take time for teenagers to feel comfortable enough to ask questions or let someone know their concerns. Four, teenagers need to be treated as individuals with respect. People have individuals needs, and time is needed to discover them. Not all materials nor programs are appropriate for everyone; individual adaptations may be necessary. Five, continuity in care is important. The teenagers in this study liked to see the same person, so they did not repeat their story. Passing people to other staff or agencies made them feel unimportant and abandoned, in addition they may have fallen through the cracks.

Society

Teen pregnancy is often viewed from a societal perspective, and it is seen mainly in terms of how teenage pregnancy affects society. For example, early childbearing is regarded as an economic burden on society; public costs include medical services, welfare, childcare, special education and programming, and lost productivity. However, society and its values, norms, and culture also affect teenage pregnancy and the experience of teenage motherhood.

When examining the "problem" of teenage pregnancy, we tend to focus attention on the individual. Over the years, prevention and intervention efforts have focused on sexuality education, access to contraception, decision-making—essentially the knowledge, skills, and attitudes of teenagers. Studies do not show these interventions to be very effective at decreasing the incidence of teen pregnancy (Steven-Simon & McAnarney, 1996) because teen pregnancy is influenced by structural as well as individual factors. Teenage childbearing does not occur at random; teenage mothers are more likely to come from a background of family instability and low socioeconomic status (Furstenberg, 1991). The majority of participants in this study came from disadvantaged backgrounds, and this was likely another level of influence on their sexual behavior and pregnancy decision. Disadvantages and limited opportunities appear to be important structural forces influencing adolescent childbearing.

In addition, teen pregnancy is influenced by prevailing social norms and values. Sexual values, attitudes, and behaviors in our society have changed tremendously over the years. Premarital intercourse has become

commonplace—almost expected, and sex has become separated from love and commitment. Sexual exploration during the teenage years is considered normal adolescent behavior. In addition, we live in a culture where sex is sensationalized and used as a marketing tool. Adolescents are influenced by sexual values and behaviors portrayed by the media, parents, and peers, and it is not abstinence that teens see nor is it responsible sexual behavior.

Society influences sexual behavior of adolescents as well as teen pregnancy through structural forces, norms, and values; however, the experience of motherhood also occurs within society and is affected by societal factors. Although there is less social stigma and fewer dramatic consequences such as a "shot-gun" wedding, pregnant and parenting teens today still feel stigmatized. The participants in this study talked about stares, comments, criticism, hostile attitudes, and being treated differently; this criticism made difficult situations more difficult. The girls also felt stereotyped as "bad" mothers. The participants felt that society needed to be more supportive and less critical and judgmental; Hardy's (1993) participants made similar comments.

In addition, the participants did not think it was fair that they received the entire blame for the pregnancy. Why is it that an unplanned pregnancy is perceived as the girl's fault? We do not typically ask, "Why didn't <u>he</u> use contraception?" It takes two people to conceive a baby, yet it is usually only the woman who bears the consequences. Society does not hold the men equally responsible for parenthood, so men have little reason to prevent pregnancy. There were few consequences for the fathers in this study; they either left altogether or appeared as they pleased and few of them provided financial

support. Without societal pressures on men to take responsibility for children they have fathered, teen mothers are left to shoulder the burden.

We are beginning to examine the role that men play in pregnancy and parenting and to develop prevention and intervention strategies that look at environmental influences. However, there are still many myths prevalent in our society. Many people still believe that early childbearing causes disadvantage—poverty, school drop out, and delinquency. There is the perception that teenage girls have babies in order to get welfare and that they choose to drop out of school. Therefore, teen mothers are still judged, criticized, and bombarded by negative stereotypes. Moreover, they have limited opportunity to present a different image of teen mothers. Few people in our society are willing to entertain the thought that teenage parenting may actually have positive effects on the lives of some girls.

Kelly (1995) completed an ethnographic study of 12 teen mothers who wrote and performed a play about their lives. One of the messages that the girls wanted to convey was that being a mother was a challenging yet positive experience. This message was not well accepted by the sponsors who want "warning stories" that would encourage the prevention of teen pregnancy. The dominant discourse in society defines teen pregnancy and parenthood as a problem with far reaching negative consequences. Even though many teen mothers do not identify with this view, society is not open to consider alternative views which makes it difficult for teen mothers to challenge stereotypes and having their stories heard.

A narration of Influences

The following fictional story, which is loosely based on the experiences of the participants, illustrates the complexity of influences on individuals.

Background

Brandy is 15 years old. Until about six months ago, she lived with her mother, younger brother, and sister. Brandy's mother had her when she was 15 years old. She and her two siblings all have different fathers, none of whom stuck around very long. Her mother has been on and off welfare for years. Brandy was sexually abused by one of her mother's boyfriends when she was 10. She was tired of having to take care of her younger siblings while her mom was out at the bar or wherever, so she left home. At first she stayed with various friends and relatives and continued going to school, but soon she was cutting school and hanging out at pool halls; this is where she met Daryl who is 23 years old. After a couple weeks she moved in with him and dropped out of school.

Brandy's story

I've had sex before but my boyfriends have usually used condoms. Daryl said he wouldn't use them because they don't feel good. I don't really like using condoms either; they ruin the moment and take away from the romance. We should use something; I don't want to get pregnant like my mom did. But I don't really feel comfortable talking with Daryl about it though. He doesn't seem to be too concerned about it. Maybe I'll just go get the pill. I'll talk to my friend, she can tell me where to go. What are the chances of me getting pregnant in the next two days? I've had sex before without using anything and never got pregnant.

My friend said there is a centre downtown that gives free birth control but she wasn't really sure where it was. It doesn't matter, it is too much hassle to try and get there anyway. Maybe I could go talk to the health nurse that visited my school on Fridays. She's pretty nice and she said in health class that she counsels teens on birth control. But that would mean having to go to school. I don't really want to go there and get hassled by teachers or the counsellor about dropping out. I don't want them to report me; I'm still under age. I guess I could go to a medi-centre.

Well, I finally went to the medi-centre. The receptionist asked me for my health card but I didn't have it. She told me to make sure I bring it with me next time. I had health care through social services when I lived with my mom, but I don't know what happens now that I'm not living there anymore. Anyway, I saw a doctor but he was really rude. I could tell he didn't approve. My friend said he would probably give me some pills for free but he didn't, so I had to go buy them. He told me to come back in a month for a pap test, then he would write me a prescription.

I'm out of pills but I don't really want to go back to that doctor. I heard about this "pap test" and I don't want no guy sticking objects in me. And, I still don't have a health care card. Plus, I don't have any money to pay for pills. The one package I bought cost $15; I couldn't believe it. I guess I'll have to find a way downtown for those free pills.

I had sex with Daryl last night even though I've run out of pills. Things just happened and it's not like I can force him to wear a condom. Besides he's the first person to really love me and I don't want to screw it up. Plus, I probably won't get pregnant. And even if I do, it might not be so bad. Me, Daryl and the baby, we could be a real family. The baby would love me and I would be able to raise it like I wanted. Daryl says he wants to have a big family.

Well, I finally went to the Birth Control Centre. But when I told the nurse that my period was a few days late she said she had to do a pregnancy test before giving me some pills just to make sure I wasn't pregnant. And guess what I'M PREGNANT. I was kind of shocked. I knew it was possible but now its really happening. I'm scared but its kind of exciting at the same time.

The cycle of teenage pregnancy continues...

Conclusions

A vast amount of data was collected in this study as the young women shared their perceptions and experiences of teen motherhood. The research findings will now be summarized as they relate to the research questions.

What are the concerns and issues of adolescent mothers who have dropped out of school? During pregnancy, concerns revolved around the baby's health, labour, and delivery, and whether they would be good mothers. Parenting teens were concerned about making ends meet, raising their children right, finding trustworthy childcare, and being alone. The participants in this study were faced with a number of issues such as meeting basic needs of food and shelter, fathers who did not take responsibility for their children, postpartum depression, lack of mobility due to transportation issues, inflexibility of bureaucracies, and criticism.

What are their perceived strengths? The teen mothers in this study felt that their youth was a strength in parenting; they relate better to their children and they are more tolerant, adaptable, and open to new ideas than older mothers. Additional strengths were patience, independence, being responsible, and understanding their child's needs. Overall, the girls felt they were good mothers and were proud that they were making something of themselves.

What are their perceived needs? It was found that the most prevalent need of participants was finance assistance. Not only did they need an adequate amount of income, but they also needed a more stable source of income. For instance, teen mothers who are on student finance lost their funding over the summer and had difficulty finding another source of income. In addition to financial support, teen mothers in this study also identified the need for other types of support:

- practical support (e.g. help with childcare, maintaining household, and a break from their children),
- affirmational support (e.g. recognizing their accomplishments and being praised for good parenting),
- emotional support (e.g. empathy and understanding),
- informational support (e.g. available community services; parenting information on topics such as developmental milestones, discipline, and toilet training; and how to deal with everyday stresses).

Participants also described needing companionship, love and affection, better prenatal classes, play groups for children under three years old that cater to

teen mothers, good daycares, and transportation. In general, teen mothers needed less stressful lives or ways to cope with the stress in their lives.

What types of services or programs would they find useful and accessible? Teens in this study liked services where practitioners were non-judgmental, took the time to talk and listen to them, explained things, and were able to develop a rapport with them. They liked services that were informal, flexible, individualized, and free. In addition, they preferred dealing with the same practitioner each time and liked services to come to them at home or at school. Other characteristics of services that were popular were "sit and gab" time, question and answer sessions, freebies (e.g. coupons or free samples), and meals or snacks served during the program. The most common factor affecting accessibility was knowledge; teen mothers needed to know about available services. Other factors that stopped girls from using a service were lack of transportation, lack of time, bad reports or experiences, the need to do it on their own, and/or no perceived need.

Implications

The findings from this study have a number of implications for practice. They are as follows:

- Since sexual activity, contraceptive use, and pregnancy are affected by many different complex factors, no single intervention will be adequate in preventing teen pregnancy. Knowledge of reproduction and access to contraceptives are necessary but not sufficient; complex psychosocial factors, social forces, and structural inequalities also need to be addressed. Teens require reasons to postpone sexual activity and pregnancy; and they need alternatives to meet the needs they are trying to fulfill. Since teen

pregnancy occurs more frequently in the context of disadvantage and since it appears to be generational, social and economic inequities should also be targeted. Furthermore, messages about healthy and responsible sexuality need to target the whole community. Too often the portrayal of sexuality and sexual norms in society works in opposition to pregnancy prevention messages. Therefore, the challenge is to develop comprehensive and coordinated strategies for prevention.

- Doctors are usually the pregnant teen's first and often only professional contact. Many pregnant teens are not in school or they drop out of school soon after discovering they are pregnant. School counselors are often unaware of the student's pregnancy. It appears that the majority of pregnant girls do not take prenatal classes nor do they use many other services during their pregnancy. Therefore, physicians need to take a more active role in assessment of the pregnant teen's situation and referral to appropriate services.
- Pregnant and parenting teens need and desire more information from the practitioners who work with them; however, they often do not feel comfortable asking questions or sharing concerns. Practitioners need to develop a rapport with teen mothers so that they feel more comfortable talking about problems and concerns. Practitioners also need to explain everything they do and check for understanding even if the teen client does not ask. Furthermore, teen mothers need to be taught assertiveness skills; they need to be confident to ask questions, state their concerns, and persist until their questions or concerns have been addressed to their satisfaction.

It would also be helpful if teen mothers knew their rights regarding health, education, and social services.

- Because rapport and relationship are very important to teen mothers, continuity of care is needed. Teen mothers are more comfortable with someone they already know, and they seem to experience less fear, anxiety, and stress if they are able to interact with the same person. In addition, they are more likely to go to someone they have established a trusting relationship with when they are experiencing problems. This means that doctors, nurses, social workers, and school counsellors should follow through with clients and not pass them to another colleague. Ideally, teen mothers would have a case manager who they trusted to coordinate services and be an advocate for them.
- Few pregnant teens are taking prenatal classes either because they did not see the need or they perceive barriers to participating in them. If we want more teens to access prenatal education then we have to offer them more options, remove barriers, and be more creative in how we present information. Initially, teen girls and their partners need to be involved in planning prenatal programs. As no one format will meet everyone's needs, there also should be a variety of choices from self-learning to one-on-one to groups. Prenatal teaching may need to be slipped in with other information or services that pregnant teens are using or interested in. Some girls think that prenatal classes are unnecessary because doctors and nurses will help them and tell them what to do. They need to understand that nurses and doctors are not able to be labour support coaches; they also do not always explain what is happening.

- Pregnancy outcomes and adjustment to motherhood are directly affected by the levels of support the teen mother receives; however, their support systems are often unstable, conflicted, and change over time. Therefore, it is important that their supports be comprehensively assessed and reassessed over time. Professionals should help teen mothers mobilize resources and when needed, augment weak support systems with supportive interventions.
- Teen mothers are very sensitive to criticism and feel they need to do things on their own; consequently, they are often reluctant to ask for assistance and perceive advice and help as questioning their competence. Family and professionals involved with teen mothers need to be very careful in what they say and do. They need to be taught how to be supportive. Advice and help need to be offered in a non-threatening manner while still affirming and showing confidence in teen mothers' abilities. Teen mothers also need to be reassured that it is normal for new mothers to need assistance. In addition, it would be beneficial to focus on the teen mother's strengths and capacities rather than her needs or deficits and to model behaviors or share experiences rather than just telling her what to do.
- Teen girls are dropping out of school both prior to and after becoming pregnant, and if they return to school they choose to go to an alternative school. The transition from junior high to senior high appears to be where a number of teen are being lost and should be examined more closely. Schools also need to examine how they could be more effective at preventing drop out among teen mothers and how they could better meet this population's needs. Pregnant and parenting teens need more support

and flexibility; however, they may not desire to attend a special school for teen mothers for a variety of reasons. Schools need to provide more supportive environments, follow-up on dropouts, and offer teen mothers a number of options for continuing their education.

- Finances are a major concern and need for teen mothers. The current system of financial assistance has many gaps; policies and programs need to be reviewed and changed. Teen mothers are in limbo; they fall between child welfare system and social services, and they may or may not qualify for student finance. There needs to be more collaboration between systems so that teen mothers are not bounced back and forth and never helped. A strategic and comprehensive plan to coordinate services for pregnant and parenting teens would be most useful.
- There needs to be more outreach to the men who are fathering these children. They need to be encouraged to take responsibility and be involved in their children's lives. Society needs to give these men the message that it is not okay to father a child then walk away; there needs to be consequences for them so they do not continue this pattern of behavior. Prevention and intervention efforts also need to target these men.

Recommendations

These recommendations are based on the findings from this study and the literature.

- Practitioners who work with pregnant and parenting teens including doctors, nurses, counsellors, social workers, and teachers should have inservice training on issues related to adolescence and teen pregnancy.

- All service providers who identify a teen pregnancy should follow an assessment and referral protocol.
- Postpartum nurses doing home visits should have a different protocol for interacting with teen mothers including increased frequency of contact and longer follow-up.
- All agencies and organizations that provide services to pregnant and parenting teens should have mechanisms in place to elicit feedback about the agency, the staff, and the services from the clients. This information should then be used in improving service delivery.
- Schools should follow-up on all teen girls who drop out, track attendance and school drop out rates of teen mothers and develop meaningful outreach service for teen mothers.
- All junior high and high schools should have books on teen pregnancy in their libraries such as "Dear Diary, I'm pregnant" by Anrenee Englander. They should also have information on community services for adolescents.
- A handbook or newsletter outlining services and resources for teen mothers should be developed.
- More resources relevant to teen mothers and father and their issues should be developed with their assistance and easily available.
- A data system should be developed to track the teen pregnancy rate, live birth rate, abortions, low birth weight, health status, school status, and other variables.
- A clearinghouse should be established to collect and disseminate information on research, interventions, and services relating to teen pregnancy.

- Community development approaches should be used to mobilize community resources including churches to help develop supportive networks for teen mothers.
- A program that creatively combines financial aid and work experience would greatly benefit teen mothers. One example, subsidizing businesses or organizations to employ teen mothers in positions would give them valuable experience or skills or financial assistance to them in summer months while they participant in parenting groups and do volunteer work.
- A fathering intervention should be initiated to help young fathers become active, responsible parents. The intervention should help young men with their life-course development. Mentoring, mediation, and prevention strategies could be used.
- Education, social service, child welfare and student finance policies should be changed so they are more favorable for teenage parents and give them a fair chance at success.

Ideally, every teen girl who has had a pregnancy confirmed by a professional would receive follow-up counselling and would be assigned a case manager who would coordinate services. There would be a team of professionals (family doctor, obstetrician, pediatrician, nurse, child welfare worker, social worker, school counsellor, psychologist) specially trained to work with pregnant and parenting teens in each area of the region. Prevention and intervention would occur simultaneously. Interventions would be holistic including the father and the teen's family and would be individualized to the teen's circumstances and pregnancy decision.

Suggestions for Further Research

This study has provided some useful information on a group of teen mothers in the Capital Health Region; however, there continues to be a need for additional research with this population. The exploratory nature of this study has stimulated ideas for further research.

- More qualitative studies with teen mothers (TMs) are needed to better understand their perceptions and experiences especially studies that look at different groups such as TMs who stay in school versus TMs who drop out, younger versus older TMs, TMs from different socioeconomic backgrounds, and TMs from different regions. Such studies would be helpful in determining additional factors that influence teen pregnancy and the experience of teenage motherhood for various groups.
- A qualitative study that looked at the experience of teenage pregnancy and parenting from a variety of perspectives such as the teen girl, the father, the parents, and other family and friends would provide a broader, more holistic view of the impact of teen pregnancy.
- Surveys could be used to gather information from larger samples of pregnant and parenting teens to determine whether qualitative findings are valid for the larger population.
- Longitudinal studies are needed. Studies that follow teenage mothers for a longer period of time would provide a picture of changing needs and resources as well as long term outcomes. In addition, a study that followed a cohort of girls from the ages of 12 to 19 to investigate factors affecting initiation of sexual intercourse, use of contraception, occurrence of pregnancy, and pregnancy outcomes would provide very useful data.

- Teen pregnancy and school-related variables such as attendance, drop out, and achievement need to be explored further. The method of grounded theory could be used to study the process of dropping out among teenage mothers.
- Action research could be used to develop resource materials or programs for pregnant and parenting teens. It could also be used to empower teen mothers and help them take action on issues they identify.
- Since support is such an important factor in the teen mother's experience, research needs to be undertaken to determine what teen mothers perceive as supportive and how existing support systems can be strengthen. Also, more research needs to be done on the negative aspects of relationships and social networks.
- There are many questions that need to be answered about the men who impregnate adolescent girls. Who are they? What is affecting their use of contraception? What are their beliefs and attitudes about fatherhood? What is their affect on the adolescent girl's pregnancy decision? What is their experience of fatherhood? Why do they not take responsibility for their children? Why are older men with young girls and why are they not more sexually responsible?

Reflections: How does this study relate to health promotion?

I was talking with someone at a meeting about my thesis, and she asked, "How is that related to health promotion?" I was somewhat surprised as I thought it was obvious. This made me realize that I cannot assume others have a common understanding of health or health promotion or that they see the connections between teenage pregnancy and health promotion that I assume.

Sometimes when I told people about my thesis topic, they assumed that I am doing a Master of Education because my undergraduate degree was in Education. My topic could easily have been an Education masters topic, so what makes it a health promotion study? To me, it is the way one approaches the topic and the focus one takes. For example, someone with a strict educational stance would likely focus on educational experiences and school related issues. Then he or she would have written implications and recommendations for educational institutions. Professionals seem to approach a topic with their discipline glasses on, and they only consider relating research to their discipline. A health promotion focus, on the other hand, requires one to look a topic or situation more holistically from a diversity of angles and perspectives.

In health promotion, health is generally defined broadly. It is more than the absence of disease or physical wellness. Health has many dimensions including physical, emotional, mental, social, and spiritual; and it is affected by socioenvironmental conditions as well as biological and behaviorial. I developed this study from this socioenvironmental concept of health and the notion of health promotion as the process of enabling people to take control over and improve their health. Teenage pregnancy and parenthood is very much a health issue and would benefit from health promotion action. Most of the health determinants[19] (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994) play a role in teen pregnancy and parenthood. In the literature review, poverty and family environment were identified as structural factors affecting teen pregnancy. Furthermore, the

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[19] Health determinants are: income and social status, social support networks, education, working conditions, physical environments, biology and genetics, personal health practices and coping skills, healthy child development, and health services.

methods used in this study respect health promotion principles in the inclusion of social context and the participation of individuals in presenting their realities and voicing their needs, concerns, and strengths. The findings are analyzed from ecological and sociological perspectives. Both individual and structural factors are addressed and a model that depicts the dynamic relationship among variables is presented.

In addition to this, numerous implications and recommendations are outlined that are consistent with the five action strategies of the *Ottawa Charter on Health Promotion* (World Health Organization, 1986). For instance, teaching assertiveness and communication skills *develops personal skills*; establishing rapport and using case management *creates supportive environments*; action research and community development *strengthens community action*; redefining and expanding the role of doctors and nurses helps *reorient health services*; and examining and changing rules, regulations, and policies in schools, agencies, and government bureaucracies starts to *build health public policy*. So what does teen pregnant and parenthood have to do with health promotion—EVERYTHING!

Strengths and Limitations of the study

This study focused on the experiences of a small group of young mothers in an urban setting. Participants were selected using purposive convenience sampling. Since the sample was not randomly selected and was small, the participants may not be representative of the larger pregnant and parenting teen population. Girls who volunteered to be part of the study may be different than those who did not; for example, teen mothers who are not coping well with motherhood may have been more reluctant to volunteer.

A limitation of this study is that the majority of participants were attending school although they all had dropped out of school in the past. The intention of the study was to focus on teenage mothers who were not in school but this is a difficult to reach population and few volunteered from among this group. However, the sample provided rich and valuable data on school and pregnancy experiences.

A strength of the study is the diversity of the sample. The participants were recruited through a variety of channels including a support group, posters, an agency referral, and an outreach school. They were diverse in terms of their backgrounds, socioeconomic class, and ethnicity. The sample also included girls who were pregnant only, parenting only, and pregnant and parenting. The participants were between the ages of 16 and 20, but they had their first pregnancy between ages 14 and 18, resulting in a diversity of ages being represented.

The diversity of the sample strengthened the generalizability of the findings, but it also reduced the likelihood that differences in experiences between teen mothers of different backgrounds would be visible. Although data from a small sample of urban teen mothers cannot be assumed to be generalizable to all teen mothers, the contextual data provided could help others evaluate how applicable the findings are to other groups. Some of the findings are specific to services available in a particular city, yet the general themes about needs, perceptions, and barriers might still be valid for similar populations in other cities.

The rapport I established with the participants further strengthened the study. Participants chose the location of the interview, so they felt more in

control and more comfortable. In addition, they were put at ease by the informal conversational style of the interview. I had follow-up discussions with the majority of the participants and ongoing contact with three participants, which enhanced the credibility of the findings. Interviewing a participant prenatally and again postnatally and including participants at various stages (pregnancy, postpartum, and parenting children from newborn to 3 years old) also enriched findings.

Summary

In summary, participants in this study tended to have a family background characterized by divorce, single parenthood, family dysfunction, and instability; they were independent at a young age and many of the girls experienced abuse. Participants also had a number of similar perceptions and experiences of motherhood. They experienced a mix of emotions when they found out they were pregnant and received mixed reactions when they shared the news with the father, their family, and their friends. Participants were generally against abortion and adoption as a personal choice. During their pregnancies, the levels of support varied depending on the relationship they had with their families. All participants saw a doctor but only a few took prenatal classes. Many of their experiences with doctors and nurses were negative or unhelpful. Despite some difficulties, the majority of participants enjoyed being pregnant.

The girls found motherhood to be tiring and difficult as well as exciting and rewarding. They felt they were good mothers and that, overall, having a child had positively affected their lives even though it restricted them in some areas. Support was identified as important, but the size and stability of their

social support networks varied. Although a number of participants were living with family postpartum, many of them moved out after a short time. They relied on a variety of financial sources (student finance, social services, parents, employment, and child tax credit) to "make ends meet"; however, dealing with the system was difficult and frustrating. Most participants did not receive financial assistance from their children's fathers, and the majority of fathers had no or little involvement with their children.

Pregnant girls were concerned about the baby's health and labour while parenting girls were concerned about finances, loneliness, raising their children right, and childcare. Participants talked about needing support, yet they had difficulty asking for help. They also had the need to be independent and to do things on their own. These factors influenced their use of services along with other barriers such as not knowing about services, cost, and distance. Most of the girls were continuing their education in outreach schools.

The central theme in the findings was "relationship". Relationships with the child's father, boyfriends, family, friends and professionals greatly impacted the girls' lives. The ability of health, education, and social service workers to establish rapport with the teens was key to continued service use and positive relationships. A number of systems including the individual, family and friends, community, services, and society influenced pregnant and parenting teens through relationships. The cumulative effect of these systems on teen mothers influenced their experience of motherhood, and because influences were diverse so were experiences. The challenge for practitioners is to maximize the positive influences on teen mothers and minimize negative ones so that these young mothers and their children can thrive.

Reflections: The Research Process

I enjoyed conducting this year long research study, but at times it was mentally draining. Every step of the research was a learning process. For example, I struggled with issues regarding involvement with participants. I knew that qualitative researchers got close to their participants and involved in their lives, but I found few details about this involvement in the literature nor did I find information on what was or was not ethical on part of the reseracher. Reading about other qualitative researcher's experiences, such as Patricia Maguire's work (1987) with abused women, help me think through issues such as lending or giving money. Nevertheless, I had to make a number of split-second decisions when participants asked me things like "Can you pick me up a pack of smokes?" "Can you baby-sit tonight?" "Why don't you come with us tonight [to the bar]?"

The facilitators at the support group did not agree with my personal involvement with the participants. They felt my involvement crossed professional boundaries; professionals should maintain a "professional distance". Although professionals may have codes of professional conduct and policies that they are to adhere to, I did not consider myself as functioning in a professional capacity but a researcher capacity. In any case, I do not feel I ever acted unethically. We all need to know our boundaries as individuals but I do not believe that "distance" is necessary to maintain ethical relationships. I believe that one reason peer interventions are preferred is because many professionals remain distant from the people they serve, and they relate on a professional-client basis rather than on a person-person basis.

As the study unfolded, I needed to learn qualitative data analysis. I had read numerous articles or chapters on data analysis, but they all seemed vague and fussy. Morse & Field (1995) state that techniques, cognitive processes and creativity are all part of the process, while May (1994) talks about the magic of creativity and intuition in qualitative methods. I used the cognitive process outlined by Morse & Field (1995) but I also found that a large part of data analysis was a process of mental immersion. I constantly pondered and reflected upon the data; I would sit for hours just staring at and thinking about the data and emerging categories. This mental soaking and sorting process was used to find common themes.

The process of writing forced me to do further analysis and synthesis; writing helped me to clarify and articulate my thoughts. However, I was frustrated because I could not always put everything in words. Biddle (1995) expressed a similar frustration "I know more that I can tell" (p. 204). After I would write a chapter, I would think of all the things I forgot to say and of details that should be included. Often I would go back and add details or paragraphs, but at some point I just had to stop. I cannot possibly write everything that is in my head. As VanManen (1990) said "Lived life is always more complex than any explication of meaning can reveal" (p. 18).

Even though the research and writing are completed, I feel I have more questions than answers. I feel I should continue to do research, obtain more answers, but at the same time I struggle with the value of research without action. Research should have a purpose; something should come from it. The only thing I regret is that there is not something more tangible from the study for the participants. I wish I could promise them that there would be some

action, some change; however, I have no control over whether my findings are used or acted upon by anyone but myself. I will inform others of the findings of this study and search for ways to take action myself. I know I have benefited from the experience and I think the participants benefited from reflecting on their situations and having someone listen to them. Hopefully, others will also hear their voices and be compelled to take action.

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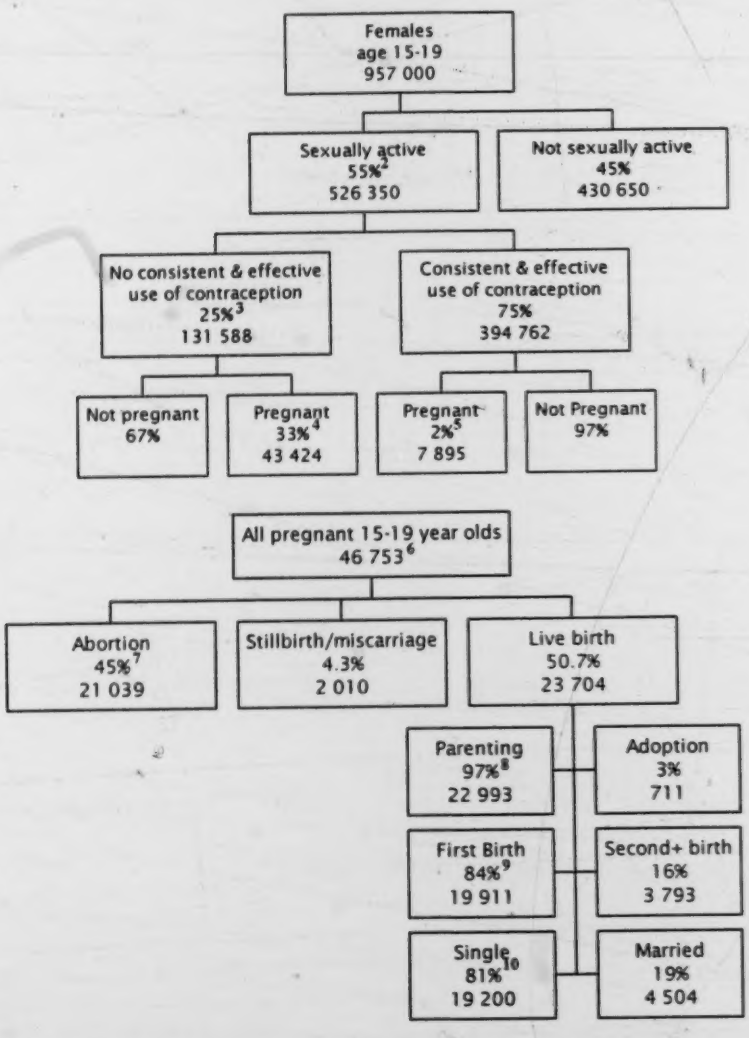
Appendix A

ESTIMATED ADOLESCENT REPRODUCTIVE HEALTH STATUS

Canada, 1994



[1] Wadhera & Millar (1997).

[2] Percentage reported by Bibby & Posterski (1992) from their national survey of Candadian adolesents.

[3] Based on percentages reported by Schnirer (1996) and Wadhera & Millar (1997).

[4] Based on figures report by Jorgensen (1993).

[5] Based on figures report by Jorgensen (1993) and known failure rates of contraceptives.

[6] Number reported by Wadhera & Millar (1997). They indicate that this figure is likely an underestimate of the total number of pregnancies that actually occur because it doesn't include non-hospitalized miscarriages and illegal abortions.

[7] Abortion, still birth, and live birth figures presented by Wadhera & Millar (1997).

[8] Percentage reported by Sells & Blum (1996).

[9] Calculated from information provided in Wadhera & Millar (1997).

[10] Percentage reported by Wadhera & Millar (1997).

Appendix B

ADVERTISEMENT FOR PARTICIPANTS

Attention Teen Moms

I am doing a research study and would like to talk to young moms about their issues and concerns. You need to be pregnant or parenting, between 15 and 19 years old, and must have dropped out of school.

This research is important in developing services and programs that young moms would find useful.

If you are interested call Karen at 437-6092 to find out more information. If I am not there, please leave a message telling me your name, phone number, and when I can contact you.

If you know any young moms, please take an information card and give it to them. Thank you.

Appendix C

SAMPLE INTERVIEW GUIDE

1. **Tell me about being a teenage mother**

   Probes:
   How did you feel when you first found out you were pregnant?
   Did you want the pregnancy?
   How do you feel now?
   What has it been like as a teenage mother?
   Tell me about a typical day.
   How has having a child affected your life?
   How much time do you spend with your child?
   What kinds of things do you do with your children?
   Who helps you and your children?
   How do you manage financially?
   How would you describe yourself as a mother?

2. **What are your strengths as a teen parent?**

   Probes:
   What are the good things about being a parent?
   What makes you a good parent?

3. **What are your needs as a teen parent?**

   Probes:
   What are some of your concerns as a teen mother?
   What things would you like help with?
   What would help you be a better parent?
   What would help you reach your goals?

4. **Tell me about the services or programs you have used as a teen mom.**

   Probes:
   Pre-natal? Health for Two? Public health nurse visits? Terra services? Social assistance? Child welfare? Subsidized housing? Family planning/ birth control? Child care?
   Tell me how you found out about these programs/services.
   How much did you use them?
   What did you think of these services/programs?
   How were you treated?

Tell me about services you would find useful.
i.e. What does (child care) mean to you?
What do you need in order to be able to use services?
i.e. What do you consider as (close, affordable)?

5. **Tell me about dropping out of school**

Probes:
How were you doing in school before you were pregnant?
How did becoming a parent affect your schooling?
When did you drop out of school?
Why did you drop out of school?
Do you have any plans to return to school?
Would you prefer to go to a regular school or a special school for teen mothers?
What would it take for you to return to school?

6. **What are your goals/plans for the future?**

Probes:
What are your views on education and work?
What are your career goals?
Have your goals changed since becoming a parent?
What are your plans regarding marriage and more children?
What could prevent you from reaching these goals?

7. **Is there anything else you would like to share with me about your experiences as a teen mother?**

8. **Is there anything you would like to ask me?**

Appendix D

INDIVIDUAL CONSENT

Project Title: The experiences of adolescent mothers who have dropped out of school

Karen Mykietka (student)
Centre for Health Promotion
University of Alberta
Phone: 437-6092

Dr. Maryanne Doherty-Poirier (supervisor)
Department of Secondary Education
Faculty of Education, University of Alberta
Phone: 492-5769

Karen is a Master's student at the University of Alberta. In this study Karen will ask me to talk about being a teen mom. What I tell her may help improve services for teen moms. The talk will take place in a private, quiet place that Karen and I both choose. The talk will be about one hour long. A second or third talk with Karen may be needed.

The talk will be tape recorded and written out in notes. The notes will be private and will only be seen by Karen and those helping her. The information from the notes will be written up in a paper so other people can read it. My name will not be used. No one, expect Karen, can match my name to what I say. Neither my parents nor friends will be allowed to sit in on the talks nor listen to the tapes. The information I give may be used to teach others and may be used in an article. What I say may be used in another study, if the study is okayed by an ethics board.

During the study this form will be kept locked up. The tapes and notes about the study will be locked in a separate place when not in use. Karen will tear up and throw away this form one year after the study is over. Karen will keep the notes and the tapes for 7 years, then the notes will be torn up and the tapes will be erased.

I will not be paid or get special care for being in the study. I know that the information from this study may help others. I can refuse to answer any question. I can quit any time I want just by talking to Karen. I will not be punished for quitting.

If I tell Karen anything that suggests I or my children may be in danger, Karen will talk to me about this. Karen may ask a public health nurse or outreach worker to come see me if she's worried about me or my children.

If I want a know about the results of this study, I will fill out the next page. The results will be available in the spring sometime.

If I have more questions, I can call Karen at 437-6092 or Maryanne Doherty-Poirier at 492-5769. I have a copy of this form.

I, _____ (please print) agree to be in this study.

Signature: _____ Date: _____

Researcher's Signature: _____

STUDY RESULTS

If you want to receive information about the results of this study, please fill out this form and return it to Karen Mykietka.

Please print.

Name _____

Address _____

_____

Postal Code _____

Appendix E

INTERVIEW BACKGROUND DATA FORM

Code number: _____ Date: _____

1. Age:_____

2. Ethnic origin:
   _____Caucasian
   _____Native
   _____Black
   _____Asian
   _____Other:_____

3. Marital Status:
   _____single (never married)
   _____married
   _____common-law
   _____separated
   _____divorced

4. Education:
   last grade
   completed_____
   age when completed_____

5. Employment:
   current_____
   past _____
   _____

6. Living Situation:
   _____by myself
   _____with husband/boyfriend
   _____with parents:
   mother, father, both
   _____with relatives:_____
   _____other:_____

7. Household annual income:
   _____under $5,000
   _____$5,000 to $9,999
   _____$10,000 to $14,999
   _____$15,000 to $19,999
   _____$20,000 to $24,999
   _____$25,000 to $29,999
   _____$30,000 to $39,999
   _____$40,000 to $49,999
   _____$50, 000 or more

8. Income source:
   _____employment: full or part-time
   _____parental support
   _____boyfriend/husband support
   _____social assistance
   _____other: _____

9. How much money do you have to spend a month? _____

10. What expenses does this money have to cover?
    _____housing
    _____food
    _____personal expenses
    i.e. clothes
    _____child expenses
    _____spending money

11. How many times have you been pregnant? _____

	Sex M or F	Age	Father's initials	Father's Involvement	Planned Pregnancy?	Was using birth control?
1st child						
2nd child						
3rd child						

Services used since first pregnancy:

_____ Health for two (milk coupons)

_____ prenatal physician visits

_____ prenatal classes:

where _____

_____ public health nurse postpartum home visits:

number of visits _____

_____ Terra:

counselling, home visits, school, other_____ (circle services used)

_____ Well-child clinics (immunizations)

_____ family planning/birth control services:

agency:_____

_____ subsidized child care

_____ social assistance

_____ child welfare

_____ student finance

_____ other: _____

_____

_____

Appendix F

ADDITIONAL QUESTIONS

(added after first interview)

1. Even when services are there (like nurse home visits and teen prenatal classes) many teens do not use them. Why do you think that is?

2. Is it hard to admit you need help or ask others for help? Why?

Appendix G

REVISED INTERVEW GUIDE

Pregnancy	When you first thought you were pregnant what did you do? To whom did you first talk to? When & where did you have the pregnancy confirmed? How did you feel when you first found out you were pregnant? What were the circumstances surrounding the pregnancy? What is/has been the most difficult part of the pregnancy? How did others react to your pregnancy? How did the labor & delivery go? How were the doctor and the nurses?
Parenthood	What has it been like as a young mom? How do others react to you and your child? Tell me about a typical day. How will it change after the baby comes? What kinds of things do you do (plan to do) with your child? Who (will) helps you and your child? How do they help you? What other way could they help you? How do you manage financially? How would you describe yourself as a mother? How will/has having a child affected your life?
Strengths	What are your strengths as a teen parent? What are the good things about being a parent? What makes you a good parent?
Needs	What would have been of helped to you during your pregnancy? What would be helpful now that you are parenting? What are your needs as a teen parent? What are some of your concerns as a teen mother? What things would you like help with? What would help you be a better parent?

Services

Tell me about the services/programs you have used since you became pregnancy
How did you find out about these programs/services?
How were you treated?
How helpful were these services?
What other way could they have been helpful?
What concerns or issues did you discuss with your doctor?
What other services would you find useful?
Is there anything that prevents you from using services?
Why haven't you used some of the services that are available? i.e. prenatal, nurse home visits
Is it hard to admit you need help or ask others for help? Why?

School

Tell me about your school experience.
When did you drop out of school?
Why did you drop out of school?
How were you doing in school before you were pregnant?
Where you able to discuss your pregnancy with anyone at school?
How did becoming a parent affect your schooling?
What did/do you like best about school?
What did/do you like least about school?
Do you have any plans to return to school?
Would you prefer to go to a regular school or a school for teen moms?
What would it take for you to return to school?

Future

What are your goals/plans for the future?
What are your views on education and work?
What are your career goals?
Have your goals changed since becoming a parent?
What are your plans regarding marriage and more children?
What could prevent you from reaching these goals?

Anything Else

Is there anything else you would like to share with me about your experiences as a teen mother?

Me

Is there anything you would like to ask me?

Appendix H

FOCUS GROUP CONSENT

Project Title: The experiences of adolescent mothers who have dropped out of school

Karen Mykietka (student)
Centre for Health Promotion
University of Alberta
Phone: 437-6092

Dr. Maryanne Doherty-Poirier (supervisor)
Department of Secondary Education
Faculty of Education, University of Alberta
Phone: 492-5769

Karen is a Master's student at the University of Alberta. In this group Karen will ask me to talk about being a teen mom. What I tell her may help improve services for teen moms. The talk will be with 5 to 7 other teens in a place we agree on. The talk will be about one hour long.

The talk will be tape recorded and written out in notes. The notes will be private and will only be seen by Karen and those helping her. The information from the notes will be written up in a paper so other people can read it. My name will not be used in the paper. Only Karen and the other teens in the group will know what I say. The information I give may be used to teach others and may be used in an article. What I say may be used in another study, if the study is okayed by an ethics board.

During the study this form will be kept locked up. The tapes and notes about the study will be locked in a separate place when not in use. Karen will tear up and throw away this form one year after the study is over. Karen will keep the notes and the tapes for 7 years, then the notes will be torn up and the tapes will be erased.

I will not be paid or get special care for being in the study. I know that the information from this study may help others. I can refuse to answer any question. I can quit any time I want just by talking to Karen. I will not be punished for quitting.

If I tell Karen anything that suggests I or my children may be in danger, Karen will talk to me about this. Karen may ask a public health nurse or outreach worker to come see me if she's worried about me or my children.

If I want a know about the results of this study, I will fill out the next page. The results will be available in the spring sometime.

If I have more questions, I can call Karen at 437-6092 or Maryanne Doherty-Poirier at 492-5769. I have a copy of this form.

I, _____(print) agree to take part in the focus group.

Signature: _____ Date: _____

Researcher's Signature: _____

Appendix I

FOCUS GROUP PARTICIPANT INFORMATION

General information

1. Age: _____

2. Ethnic Origin:
   ___ Caucasian
   ___ Native
   ___ Black
   ___ Asian
   ___ Other: _____

3. Marital Status
   ___ single (never married)
   ___ married
   ___ common-law
   ___ separated
   ___ divorced

4. Current Living situation
   ___ by myself
   ___ with husband/boyfriend
   ___ with parents: mother, father, both
   ___ with relatives: _____
   ___ other: _____

5. Household annual income:
   ___ under $5000
   ___ $5,000 to $9,999
   ___ $10,000 to $14,999
   ___ $15,000 to $19,999
   ___ $20,000 to $24,999
   ___ $25,000 to $29,999
   ___ $30,000 to $39,999
   ___ $40,000 to $49,999
   ___ $50, 000 or more

6. Income source:
   ___ parental support
   ___ boyfriend/husband support
   ___ child maintenance
   ___ student finance
   ___ employment: full-time/part-time job: _____
   ___ other: _____

7. Your monthly income from all sources
   $_____

8. Your monthly expenses (only expenses that you pay from your income):
   Housing & Utilities $_____
   Food $_____
   Child expenses $_____
   Travel expenses $_____
   Spending money $_____
   _____ $_____

9. Check which statements are true.
   ___ I always have enough money.
   ___ I usually have enough money.
   ___ I often don't have enough money.
   ___ I have to sometimes borrow money or use services like the food bank

10. If you are on Student finance, how do you support yourself during the summer months?
    ___ stay in school & on student finance
    ___ find a summer job
    ___ go on social assistance
    ___ other: _____

11. From the ages of 0 to 18 I lived with: (please your age in each living situation)
    _____ My mom & dad
    _____ My mom
    _____ My dad
    _____ Mother & stepfather
    _____ Father & stepmother
    _____ Relatives
    _____ Foster care
    _____ Friend's family
    _____ On my own
    _____ With boyfriend
    _____ With friend

Sexual/personal history

12. I first had sex at the age of_____

13. I have used the following contraceptive methods (please check all that apply)
____ birth control pill
____ condom
____ diaphragm
____ sponge
____ withdrawal
____ other

14. I am currently sexually active
Yes No

15. My current method of contraceptive is:
_____

16. I have experienced:
____ verbal abuse
____ physical abuse
____ sexual abuse

Pregnancy

Pregnancy number	Your Age	Father's Initials	Father's Age	Contraceptive Used	Circum-stances	Pregnancy Outcome
1						
2						
3						
4						

Circumstances:
a) lack of information on contraceptives
b) no contraceptives available at time
c) too shy to discuss contraceptives with partner
d) didn't think I would get pregnant
e) wanted to get pregnant
f) other: please specify

Pregnancy outcome:
abortion
miscarriage
adoption
parenting

Children

Child	Age in months	Father's Involvement
1		
2		
3		

Father's Involvement:
a) none
b) sees child once in a while
c) is involved a lot but does not live with child
d) lives with child
e) gives financial support

School

Have you ever dropped out of school? Yes No
If you have when & why? List grade, number of months, and reason

Grade	# of months	Reason

Services please check the services you have used

_____ Health for two (milk coupons): Month started?_____ Finished?_____
_____ prenatal physician visits
_____ prenatal classes: where_____
_____ public health nurse postpartum home visits: number of visits _____
_____ Terra: counselling, home visits, school, other_____ (circle)
_____ Well-child clinics (immunizations)
_____ family planning/birth control services:
agency:_____
_____ subsidized child care
_____ social assistance
_____ child welfare
_____ student finance
_____ other:_____
_____

Future

School
_____ I plan to finish high school
_____ I plan to go to college/university to study _____
_____ I plan to take a year off before going to college/university

Marriage
_____ I would like to eventually like to marry
_____ I don't plan on ever getting married
_____ I plan to get married in the next two years

Children
_____ I want more children but not for a long time
_____ I don't want any more children
_____ I want to have another child in the next 2 years.

Any other plans?

Is there anything that could stop you from reaching these goals?

Appendix J

FOCUS GROUP INTERVIEW GUIDE

Pregnancy	When you first thought you were pregnant what did you do? When & where did you have the pregnancy confirmed? How did others react to your pregnancy? Baby's father? Parents? How did you feel when you first found out you were pregnant What is/has been the most difficult part of the pregnancy? How were the doctor and the nurses that delivered your baby?
Parenthood	What has it been like as a young mom? How you experienced a lot of criticism? from who? Who helps you and your child and how? How would you describe yourself as a mother? How will/has having a child affected your life?
Strengths	What are your strengths as a parent? What makes you a good parent? Do you think it is better to parent when you are young?
Needs	What would have been of helped to you during your pregnancy? What would be helpful now that you are parenting? What other way could people help you? What are your needs? Concerns?
Services	*H for 2/TALKS*: How did you find out? How helpful? *Doctor visits*: What issues/concerns? What info given? How treated? *Prenatal*: How helpful? Why didn't you take? *Public Health nurse*: How did you like? *Terra*: How did you find out? What services used? How helpful? *Child care/Social Assistance/Child Welfare/Student Finance*: Comments? What other services would you find useful? Is there anything that prevents you from using services? Is it hard to admit you need help or ask others for help? Why?
School	How were you doing in school before you got pregnant? What did/do you like best about school? Least?
Future	What are your goals/plans for the future? Have your goals changed since becoming a parent? What are your plans regarding marriage and more children? What could prevent you from reaching these goals?
Anything else	Is there anything else you would like to share with me about your experiences as a teen mother?

Appendix K

SUMMARY OF PARTICIPANT CHARACTERISTICS

Characteristics		Number of participants	
		Interview (n=7)	Focus group (n=6)
Age	16	1	2
	17	1	-
	18	2	2
	19	2	2
	20	1	-
Race	Caucasian	5	3
	Native	1	1
	Metis	1	2
Marital Status	Single	5	4
	Married	1	-
	Common-law	1	2
Current Living Situation	Independently	2	2
	With parent(s)	1	2
	With boyfriend/husband	2	-
	With boyfriend+his family	1	2
	With a foster family	1	-
Financial support	Single source	3	2
	Combination of sources	4	4
Financial sources	Student Finance	3	3
	Social services/child welfare	2	-
	Parent(s)	1	2
	Employment	2	1
	Boyfriend/husband	1	-
	Partner's family	1	2
School	Currently attending	5	6
	History of dropping out	7	6
Situation at time of first interview	Pregnant	1	2
	Parenting	5	4
	Pregnant & parenting	1	-
Total number of pregnancies	1	4	6
	2	1	-
	3	-	-
	4	1	-
	5	1	-
Ages of children		Newborn to 2.5 years	9 months to 3 years

Appendix L

PREGNANCY DATA

Partici-pant	Age at 1st sex	Pregnancy number	Age at pregnancy	Father's age	Contraceptive used	Pregnancy outcome	Father's Involvement
A	12	1	14	20	none	miscarriage	----
		2	15	21	pill (took antibiotics)	miscarriage	----
		3	16	22	none (told was infertile)	parenting	was involved for 3 yrs
		4	17	23	none (planned)	parenting	was involved for 2 yrs
		5	19	24	pill	miscarriage	----
B	12	1	15	17	pill	abortion	----
		2	18	19	none (planned)	miscarriage	----
		3	19	22 or 25	none (planned)	parenting	none
		4	20	29	none	abortion	----
C	14	1	17	25	pill (took one pill late)	parenting	none
D	14	1	15	17	pill	parenting	was involved (in jail)
E	14	1	15	17	condoms sometimes	parenting	involved
F	14	1	16	15	none	parenting	none
G	15	1	15	16	condoms sometimes	parenting	none
		2	17	20	condoms + spermicide	parenting	minimal
H	16	1	17	18	pill (took antibiotics)	parenting	has custody
I	11	1	15	14	pill (took irregularly)	parenting	none
J	14	1	15	22	none	parenting	none
K	12	1	15	17	pill (took irregularly)	parenting	lives with K & child
L	14	1	16	19	none	pregnant	involved in pregnancy
M	16	1	18	21	pill	pregnant	lives with M